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ABSTRACT

Health problems among the American Indians have been of major concern to the U.S. Public Health Service for some time. As major inroads are now being made into infectious diseases, maternal and child health, and many chronic illnesses, the problems of the mental health of Indians come into a more central focus. Within the framework of mental health problems, suicide looms as one of the more tragic outcomes of psychological anguish. At the same time, it is one of the most preventable and unnecessary modes of death. The long history of social and cultural turmoil that has confronted the American Indian has created unique problems, and one of the outcomes is an increase in suicide and other self-destructive behavior. It was within this context that the National Institute of Mental Health and the Division of Indian Health (now Indian Health Service) worked cooperatively to sponsor the workshops at which the following papers (reproduced in the document) were presented: "Suicide in the United States," "Self-Destructive Behavior in Adolescents and Adults: Similarities and Differences," "Two Types of Suicidal Behavior," "Planning for Suicide Prevention," "Mental Health Services in a Sparsely Populated Area: A Necessary Complement to a Suicide Prevention Program," "Suicide and Self-Destructive Behavior in the Oglala Sioux: Some Clinical Aspects and Community Approaches," and "Suicide and Self-Destructive Behavior on the Cheyenne River Reservation." (BO)

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Suicide Among the American Indians

TWO WORKSHOPS

Aberdeen, South Dakota
September 1967

Lewistown, Montana
November 1967

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FOREWORD

Health problems among the American Indians have been of major concern to the U.S. Public Health Service for some time. As major inroads are now being made into infectious diseases, maternal and child health, and many chronic illnesses, the problems of the mental health of Indians come into a more central focus, just as has happened in the general population.

Within the framework of mental health problems, suicide looms as one of the more tragic outcomes of psychological anguish. At the same time, it is one of the most preventable and unnecessary modes of death. The long history of social and cultural turmoil that has confronted the American Indian has created unique problems, and one of the outcomes is an increase in suicide and other self-destructive behavior. It was within this context that the National Institute of Mental Health and the Division of Indian Health (now Indian Health Service) worked cooperatively to sponsor the workshops at which the following papers were presented.

LARRY H. DIZMANG, M.D.
DAVID D. SWENSON, M.D.

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SUICIDE IN THE UNITED STATES

David D. Swenson, M.D.

Chief, National Clearinghouse for Mental Health Information, National Institute of Mental Health

First, I would like to extend you greetings from the National Clearinghouse for Mental Health Information, the Center for Studies of Suicide Prevention, and the National Institute of Mental Health. This morning I would like to give you an overview of suicide in the United States, plus a brief description of the national program that is being instituted in the area of suicide prevention.

Suicide is a serious problem in the United States, as I'm sure you are aware from the fact that you are attending this workshop. Suicide is a topic in which mental health personnel throughout the United States are showing more and more interest and more and more concern. There are a number of reasons for this increased concern. Among these is the fact that suicide has been increasing and has become one of the major causes of death in the United States. In a moment, I will go into some of the statistics showing this trend. This information may be familiar to many of you, but it cannot become too familiar.

Recently, there has been an organized effort nationally to do something about this problem. A major start was made in 1958 when the Los Angeles Suicide Prevention Center began taking calls from individuals in crisis. Since that time, a number of similar programs have sprung up in various parts of the country. At present, the major program thrust is taking place at the new Center for Studies of Suicide Prevention within the National Institute of Mental Health. This Center is responsible for a large-scale administrative, training, and basic applied research program simultaneously directed at all levels of suicide prevention. The goal is to develop not only a better understanding of the suicidal crisis and how it can be dealt with more effectively but also a better understanding of the kinds of earlier positive experiences that immunize one from suicide as a psychological deterioration event or process later in life. The first actual planning for the Center at the National Institute of Mental Health began in February 1966 when Dr. Edwin Shneidman, who was at that time the co-director of the Suicide Prevention Center of Los Angeles, was asked to devise a comprehensive NIMH suicide prevention program. Dr. Shneidman later mentioned that at the time he was working on that plan he felt sorry for the individual who would have to try to implement it. Later he was asked to head up this program, which he did in October 1966; since that time he has been much too busy to feel sorry for himself.

It will take a number of years for this present national effort to make its full impact on the general mental health of the Nation, and it will take even more time for the primary prevention program to be fully implemented. In the meantime, inasmuch as there are a number of facts already known about suicide, it is imperative that every mental health worker, all medical, and all paramedical personnel become fully aware of what is already known about suicide.

In frequency, suicide is now the 10th cause of death in the United States and the first cause of unnecessary and stigmatizing deaths. This involves at least 23,000 people a year who in one way or another intentionally participate in ending their own lives. The figure of 23,000 individuals does not even begin to indicate the magnitude of the problem, as great numbers of suicides are "lost" in the reporting process. Some researchers estimate that at least 5 percent of all fatal one-car accidents are also a result of suicidal intent.

An even larger problem, at least numerically, is that of suicide attempts and threats. These number into the hundreds of thousands a year. From an economic standpoint alone, one can imagine the number of man-hours involved, including the time of police, and medical and hospital personnel—not to mention the anguish and emotional turmoil that

ensues in the families that are confronted by such a crisis.

Accurate statistics on completed suicides in the United States do not exist, but from those that are assembled annually by the National Center for Health Statistics, it is possible to project a suicide pattern—at least in terms of age, sex, race, marital status, and geographic region. First, for States in this area: for Montana, in 1965, the suicide rate was 16.0 per 100,000 population—third in the rank order of States for suicide. In comparison with all the States around Montana, North Dakota ranked 28th with a rate of 9.2; Wyoming ranked 2d with a rate of 18.5; South Dakota ranked 22d with a rate of 8.4; and Idaho ranked 16th with 11.1 per 100,000.

Among the Indian population in the United States, there were 60 deaths classified as suicide in 1965 with a rate of 12.2 per 100,000. This ratio is based on data from 23 reservation States, excluding Alaska. There have been some reservations where the rate has been more than 100 per 100,000.

The suicide rate in the United States is 10.5 per 100,000 persons. For all ages, the rate for males is higher than for females, and the rate for male suicides rises sharply after the age of 45 and keeps rising into the eighties. The national suicide rate for males is 16.6 compared with 4.9 for females. Suicides among the white population are 11 per 100,000, contrasted with a rate of 5.5 for the nonwhite population.

The marital status of an individual also has a definite relationship to potential suicide risk. For married persons, the rate per 100,000 is 11.9; for single persons, 20.9; for the widowed, the rate is 23.8; and for divorced persons, the national rate is 39.9, with the rate of 18.4 for divorced females and the extremely high rate of 69.4 for divorced males. The number of adolescent suicides is relatively low, in relation to the total population, but the risk is high. In the 15 to 19 age group, suicide is the third ranking cause of death, exceeded only by accident and cancer, or to state it another way, suicide in adolescents takes more lives than tuberculosis, all categories of fevers, streptococcal infections, rheumatic fever, diabetes and appendicitis all together. In the collegiate group, suicide is the second ranking cause of death, with rate for boys twice as high as the rate for girls.

From these brief statistics several important points can be made. Although one must always be alert for potential suicidal problems, there are several groups where the index of suspicion is very high. These groups include the white divorced male over 45, particularly if he has problems with alcohol, the age group between 15 and 19, and special groups such as the Indian population. In these groups, one should be especially sensitive to any form of behavior or communication that might convey serious emotional distress.

As has been repeatedly pointed out, large numbers of potentially suicidal persons have sought some kind of medical consultation in the 3 or 4 months just prior to their suicidal behavior. There is little question now that many of these individuals, at the time they consulted their physician, had conscious suicidal thoughts, or at least were giving "unconscious" signals. The same is true of those individuals who talk with various kinds of mental health workers, so that we all must be alert to these signals. What can be done to increase our alertness? There are five main avenues leading to the reduction of suicidal deaths.

1. *To increase the acumen for recognition of potential suicide among all possible rescuers.*

The key to the reduction of suicide lies in recognition and diagnosis—the perception of the premonitory signs and the prodromal clues. Typically, suicidal individuals cast some verbal or behavioral shadows before them. Prevention lies in recognition. This early casefinding task must be shared by both professional and lay people. The "early signs" of suicide must be made known to each physician, social worker, clergyman, policeman, and educator in the land—and to each spouse, parent, neighbor, and friend.

2. *To facilitate the ease with which each citizen can utter a cry for help.*

The tabooed nature of suicide must be recognized. A successful program of suicide prevention depends, in part, on reducing the taboos and in giving citizens in distress a greater permissiveness to seek help and to make their plight a legitimate reason for treatment and assistance.

3. *To provide resources for managing the suicidal crisis.*

Both facilities and personnel are needed. The personnel will need to acquire relevant skills and appropriate attitudes. Management and treatment of the suicidal individual, as well as his "significant others," are required for reduction of the suicide rate.

4. *To establish followup procedures for two special groups.*

(*a*) For individuals who have attempted suicide, with the specific focus on reducing the number of this group who are now unconscionably permitted to commit suicide; and

(*b*) For the survivor-victims of committed suicide—inasmuch as it is known that, if untreated, the survivor, especially a young person whose parent has committed suicide, suffers long-range deleterious mental health effects.

5. *To disseminate the facts about suicide.*

There is a vast body of mythology and erroneous folk lore concerning suicide. One of the first tasks is to disseminate the solid facts and expose the erroneous fables to all citizens—in much the same way that health facts have been publicized in this country.

The five avenues bring us to the national suicide prevention program. The primary goal of a national suicide prevention program obviously is to effect a reduction in the present rate of suicidal deaths and to do so in such a way as to be able to demonstrate unequivocally that lives have been saved. Secondary goals include stimulating basic and practical research in the areas of self-destruction and providing training in suicide prevention as well as lowering the present taboos which can hinder the serious study of suicidal problems.

With these goals in mind, the following 10-point suicide prevention program is being implemented:

1. *A program of support of suicide prevention activities in communities throughout the Nation.*

In suicide prevention, as in many other fields, needs run ahead of knowledge, and service often leads to understanding. A comprehensive program for suicide prevention therefore includes immediate application of present knowledge, with the goal of saving lives. Just as there are fire stations throughout the country, there ought to be suicide prevention centers in every part of the land. Communities throughout the country are being encouraged to inaugurate some kind of suicide prevention activity.

There are three obvious ways in which suicide prevention activities may be implemented at present.

(*a*) First, by including some suicide prevention activity as part of the emergency services in each Comprehensive Mental Health Center. It is difficult to think of comprehensive mental health services, including emergency mental health demands, without including some sort of suicide prevention activity. We know from experience that roughly 10 percent of the calls to an emergency mental health center involve some threat of self-destruction.

In addition, the consultation and educational activities of a Comprehensive Mental Health Center can be utilized to treat and/or further evaluate the suicidal individual. A suicide prevention center is primarily an evaluation and referral center, not a treatment center. Therefore, if a suicide prevention center is included in a community mental health center, a close continuum of care can be provided.

(*b*) Second, suicide prevention activity can be made a part of emergency care in hospitals.

(*c*) Third, a suicide prevention center can be developed independently, especially if there is no community mental health center or hospital with emergency care services available.

At the present time there are over 40 suicide prevention centers in the United States and the number is rapidly growing. (See note on page 6.)

It should be recognized that there are a variety of different organizational and funding models for suicide prevention activities, each growing out of the needs and peculiarities of the local community. This is especially important in the case of the American Indian whose living conditions may be very different from those of the "typical" citizen. The Center for Studies of Suicide Prevention is aware of the various models which do exist and can therefore serve in a consulting capacity to requesting communities.

2. *A program for the "gatekeepers" of suicide prevention.*

An important key to suicide prevention lies in detection and diagnosis. One of the most important findings from the experience of the Los Angeles Suicide Prevention Center is that practically every person who kills himself gives some verbal or behavioral clues of his intention to do so. These prodromal clues are often cryptic or disguised, but nonetheless they are clues and one can learn to recognize them.

In practice, a variety of kinds of people ("gatekeepers") hear or are given the presuicidal clues—

spouse, children, friends, neighbors, clergymen, policemen, bartenders, physicians, and employers. However, since many individuals who commit suicide have seen a physician (usually a general practitioner) within 3 months of the event, it therefore is crucial to have a program of education relating to detection and diagnosis directed toward physicians.

There are a number of ways in which the program for educating physicians and others in suicide prevention is being done, or can be done. These include the following:

(*a*) Preparation of special educational materials for physicians, focused on the premonitory signs of suicide.

(*b*) Introducing materials on suicide and suicide prevention in the medical school curriculums.

(*c*) Developing courses on suicide prevention in postmedical education.

(*d*) Establishing a special national conference on suicide prevention. Next year on March 20, 1968, in conjunction with the American Orthopsychiatric Association meeting in Chicago, there will be a meeting of the first Annual National Conference of Suicidology.

(*e*) Eventually, planning special programs for clergy, police, educators, social workers, and other gatekeepers of suicide prevention. On Indian reservations, this group of gatekeepers would also include members of the tribal council, the tribal judge, and VISTA workers.

3. *A massive public education program.*

Massive public education is probably the most important single type of program. For effective suicide prevention, one major avenue to the reduction of suicidal deaths is through the use of the lay citizen for firstline detection. A similar method is used to detect cancer through the effort of lay citizens who know the prodromal clues for cancer. This model, with appropriate changes, might well be adopted in suicide prevention.

At the present time, news about suicide and suicide prevention is increasing and a part of this, at least, is due to the efforts of the Center at NIMH. For example, this spring there was a *Time* essay on suicides, public affairs pamphlets have been published, and there have been numerous articles in the press. In July 1967, we published the first issue of a new journal called the *Bulletin of Suicidology*. Dr. Shneidman and I are coediting the publication, which contains original articles, news notes, and abstracts of the literature. The first issue contained an introduction by Dr. Yolles, a description of the Center for Studies of Suicide Prevention, an original article on suicide among the Cheyenne Indians, a description of a mental health development training conference on suicide, a directory of suicide prevention centers in the United States, and a bibliography (with abstracts) of 50 significant past and present articles and books on suicide and suicide prevention under the following heads: statistical and demographic, theoretical and taxonomic, administrative and organizational, remedial and therapeutic, diagnostic and evaluational, children and adolescents, legal and forensic.

The journal is distributed free at the present time and you can be placed on the mailing list by writing to the Clearinghouse. The December 1967 issue of the *Bulletin* will be coming out early in 1968. (See note on page 6.) That issue will contain articles such as the following:

"Some Current Developments in Suicide Prevention," by Dr. Edwin Shneidman

"Male Suicide: Los Angeles and New Orleans Compared," by Dr. Warren Breed

"Suicide: An Overview of a Health and Social Problem," by Dr. Louis I. Dublin

"Western Seminar on Suicide," by Dr. David Swenson

"Grants Awarded in the Field of Suicide Prevention," and

"Abstracts on Suicide."

4. *A program for followup of suicide attempts.*

We know that about eight out of 10 people who commit suicide have previously attempted or threatened it, but the data relating to the percentage of people who have attempted or threatened suicide and who subsequently commit suicide are contradictory and equivocal. Thus there is great confusion about the relationship between attempted suicide and committed suicide. This confusion exists partially because clinicians and investigators fail to think in terms of lethality. A suicidal event—whether a threat or an attempt or a commission—is best understood in terms of its lethal intention, rather than its method. We

need to know the characteristics of those attempters whose intentions are highly lethal, as opposed to those whose intentions are low in lethality. Prevention of suicidal deaths obviously lies in dealing with the former.

To investigate these characteristics, followup procedures for suicide attempts are being planned as a legitimate aspect of a comprehensive approach to suicide prevention.

5. *A program of research and training grants.*

This aspect of the comprehensive suicide prevention program includes stimulating, catalyzing, promoting, and supporting especially promising and needed-to-be-done research projects. Also, training grants are being made available for special training in suicide prevention for regional training activities and for training at specific centers. A number of grants have already been given and a number are pending at this time. As I mentioned previously, the December 1967 issue of the *Bulletin* will contain a list of grants recently awarded by the NIMH.

6. *A redefinition and refinement of statistics on suicide.*

Current statistics on suicide are grossly inadequate, and comparisons of suicidal incidents between cities, between States, and between countries, based on available figures, are sometimes inaccurate and at best often misleading. The current inaccuracies are due to many causes, including the following:

(*a*) Confusion as to how to certify equivocal deaths; for example, those which lie between suicide and accident (e.g., in some cities death is not certified as suicide unless a suicide note is found, whereas in Los Angeles over one-third of those whose deaths were certified as suicides left no notes).

(*b*) Dissembling on the part of the police and physicians who wish to protect the family, and public officials who wish to protect the reputation of their community.

(*c*) Inaccurate record-keeping, where what could be known and ascertained simply is not accurately recorded or reported.

(*d*) Inadequacies of the present concepts.

One great difficulty in reporting self-destructible deaths accurately is currently tied to an archaic classification which puts each death into one of four categories: natural, accidental, suicidal, or homicidal (the so-called NASH classification). This classification stems from the 17th century, at which time the interest was primarily the attribution of guilt or blame—whether to man or to God.

Dr. Shneidman has proposed that every death be classified in terms of the intention of the victim in relation to his own death as follows:

Intentioned. The individual plays a direct conscious role in his own demise. The death is due primarily to the decedent's conscious wish to be dead and to his actions in carrying out that wish.

Subintentioned. The deceased plays an important indirect role in his demise, and the death is due in some part to actions which seem to reflect his unconscious wishes to hasten his death. Evidences for this orientation toward death are seen in carelessness, neglect of self, gambles with death, excessive risk-taking, mismanagement of drugs, and abuse of alcohol.

Unintentioned. Deceased plays no significant psychological role in his own demise. Death is due entirely to failures within the body or to assault from without in a decedent who unambivalently wished at the time to continue to live.

7. *The development of a cadre of trained, dedicated professionals.*

There is an acute need for the creation of a core group of individuals to direct and staff the suicide prevention programs in the NIMH central office, in the regional offices, and in the communities throughout the country. What is being planned here is not the training of individuals to be therapists for suicidal people, but rather, the training of individuals in the basic ideas and facts about suicide and suicide prevention so that they can then act more meaningfully in their administrative and technical capacities.

This aspect of the NIMH suicide prevention program has been implemented by establishing fellowships in suicidology at the Johns Hopkins University. These fellowships are for people already at a professional level, M.D.'s and Ph.D.'s who have either done research in suicide or evidenced special interest in this field. Page 34 of the July 1967 issue of the *Bulletin of Suicidology* gives more details on these fellowships.

8. *Government-wide liaison and national use of a broad spectrum of professional personnel.*

This item is more a statement of attitude and approach than a blueprint for specific action. Liaison is planned not only within HEW, but with Defense, Agriculture, Urban Affairs, Labor, Office of Economic Opportunity, and so forth.

Just as there is liaison between NIMH and other governmental agencies, there should be interaction among a variety of professions, including psychology, psychiatry, sociology, epidemiology, anthropology, linguistics, philosophy, education and health education, police, clergy, and social workers.

9. *A followup program for the survivor-victims of individuals who have committed suicide.*

If one stops to consider the kind of grief work and mourning that one has to do on the occasion of the death of a loved one who dies of a natural or accidental cause on the one hand, and then what he has to do for the rest of his life if his parent or spouse has committed suicide, the contrast is clear. The individual who commits suicide often sentences the survivor to obsess for the rest of his life about the suicidal death. The suicide puts his skeleton in the survivor's psychological closet. No other kind of death in our society produces such lasting emotional scars as does a suicidal death. A comprehensive suicide prevention program should attend to the psychological needs of the stigmatized survivors, especially the children who survive a parent who has committed suicide.

Although this aspect of the program is not directed especially toward reducing suicide—dealing as it does with an individual who has already killed himself—nevertheless, because it relates to the survivors of the suicidal death, it is in the center of mental health concern. Today each citizen enjoys many rights in this country; we would also hope that he might be granted the right to lead an unstigmatized life, especially a life unstigmatized by the suicidal death of a parent or a spouse or other loved ones.

Studies of the effects of suicides on survivors are planned. These include: retrospective studies of individuals whose parent committed suicide 1, 5, 10, or 20 years ago; and prospective studies where the suicide has occurred in the very recent past and the effects on the survivor are followed through time.

10. *A program for the evaluation of the effectiveness of suicide prevention activities.*

By consultation with people in biometry, epidemiology, sociology, methodology, research design, and statistics, efforts will be made to evaluate the effectiveness of suicide prevention activities.

In summary, the 10 points of the NIMH suicide prevention program are:

1. A program of support of suicide prevention activities in communities throughout the Nation.

2. A program of education for the "gatekeepers," especially physicians.

3. A program in massive public education.

4. A program of followup of suicide attempters.

5. A program of research and training grants.

6. A redefinition and refinement of statistics relating to suicide.

7. The development of a cadre of trained and dedicated professional personnel.

8. Government-wide liaison and use of a broad spectrum of professional personnel.

9. A followup program for the survivor-victims of suicide.

10. A program for evaluating the effectiveness of suicide prevention activities.

NOTE: Some of the statistics in this article have changed since the workshops were held. At the present time there are more than 130 suicide prevention centers in the United States. The following issues of the *Bulletin of Suicidology* have now been published: July and December 1967, July and December 1968, and March 1969.

SELF-DESTRUCTIVE BEHAVIOR IN ADOLESCENTS AND ADULTS:
Similarities and Differences

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The thesis of this paper is that self-destructive behavior in adolescents and adults differs because of the differences in the psychology of the adolescent and the adult. The similarities in self-destructive acts of adolescents and adults are perhaps more superficial and related to sociocultural roles. One must constantly keep in mind that the adolescent has not had the experience of being an adult and that adults have experienced and passed through adolescence.

The tasks which normal adolescents must successfully master before they attain maturity and adulthood are various. We shall contrast some of these with the adult state and show where they relate to adolescent suicidal behavior.

The problem of control of impulses for the adolescent is different from that of the adult. Adolescents fight for precarious control of unconscious drives which are held in check by relatively weak defenses. This is in contrast to the adult whose unconscious drives are more successfully repressed and controlled by stronger defenses. Impulsivity as a factor in self-destructive behavior in adolescents is fairly common as compared to the adult.

Achieving a sense of autonomy and separation from the family is a major preoccupation of young people. This is difficult because at the point where the adolescent begins to grasp the meaning of the task he is being simultaneously pulled back into the family. He is locked into various complex relationships within the family and is treated at one moment as an immature child and the next reminded to grow up. He must struggle with the problem of gradual separation from the family members, realizing that he is still dependent upon them. Only a slight intensification of this normal struggle for independence and autonomy with attendant feelings of rejection and loss of love are often enough to precipitate self-destructive behavior in the adolescent. By contrast, adults generally have achieved some sort of emancipation and have invested in other relationships such as result from marriage and the beginning of their own families. A mature love relationship for the adult is protective against self-destructive behavior. It is only with the real or threatened breakup of a marriage or in the older adult who is faced with the dissolution of his family that the risk of self-destructive behavior is increased.

The adolescent has to struggle with the question of who he is, whom he wishes to be like, and what is to be his role in society. This is one aspect of choosing and preparing for a vocation and commitment to life. The adolescent is constantly reminded that he has not yet finished his schooling and is not yet ready to participate in adult society. The adult has a sense of who he is, his vocational choice is usually stabilized, and he is functioning in his job rather satisfactorily. His preoccupations with the future are more apt to deal with raising his family and achieving financial security. The intensity of his concern with the future may be less than that observed in the adolescent. Failure on the part of the adolescent to cope with identity problems increases risk of self-destruction.

Both young boys and young girls have to learn how to identify with members of their own sex while simultaneously being involved in the process of developing affectional bonds with members of the opposite sex as a preliminary procedure in

selection of future marriage partners. Adults have presumably worked through these conflicts and have greater sexual freedom and better understanding of the relationship between sexuality and love than have adolescents. Lack of friends of one's own sex and disappointments in adolescent love relationships are well known precipitating causes in suicidal behavior.

CHARACTERISTICS OF THE PRESUICIDAL BIOGRAPHY

Teicher and Jacobs described the biography of the child who eventually arrives at the conclusion that self-destructior is the only solution to his problem. They describe a three-stage progression leading up to a suicide attempt: (1) A longstanding preadolescent history of problems of various kinds, such as broken homes, rejection by parents, and placement in foster homes or juvenile hall, which seem progressively to isolate the adolescent from meaningful social relationships; (2) a period of escalation which is coincident with adolescence, often associated with the appearance of new problems (I see these as essentially involving a series of failures in the solution of the normal tasks of adolescence, such as the struggle for autonomy, failure to achieve an adequate identity, school failure with attendant lack of self-esteem, and inadequate working out of sexual conflicts); (3) the final stage which is described as a chain reaction dissolution of any meaningful social relationships. This final stage is often mistaken as a reason for the suicide but represents only the precipitating cause. Frequently mentioned precipitating causes are a fight with the family, an inadequate romance with its final breakup, school dropout, pregnancy, and perhaps the exodus of older siblings from the household. Teicher and Jacobs further make the point that the suicide attempt, instead of resolving the problem for the adolescent, only adds to his alienation and serves to isolate him further from those sources of support and gratification that he is seeking to attain.

A comparable biography of the adult suicide cannot be as well delineated, although we do feel that there are many clues to self-destructive potential in the adult. Most often, the adult self-destructive behavior takes place in the context of a disrupted marital status brought on by separation, divorce, or death. Frequently the person is living alone and suffers from emotional and/or physical illness for which medical help has been sought in the immediate preself-destructive period. The self-destructive behavior is apt to occur in the setting of waning abilities and/or loss of people close to the individual, resulting in an inability to face the threat of oncoming helplessness or loneliness. Factors which seem to increase the risk of lethal self-destructive behavior include unemployment, alcoholism, and prior attempts at suicide, especially if the suicide attempt was by one of the more lethal methods, and if the prior attempt was associated with psychiatric hospitalization.

SYMPTOMATOLOGY ASSOCIATED WITH SELF-DESTRUCTIVE ACTS

Depression

It is often alleged that depression is covert or absent in the suicidal adolescent. This is not really true. What has been true is that we have largely ignored symptoms. All of the symptomatology of classical adult depression can be seen in the suicidal adolescent—loss of interest in friends and family, lack of initiative and drive, feelings of sadness, emptiness, and loneliness, and eating and sleeping disturbances. But delinquent behavior, sexual promiscuity, and frenetic activity can be as indicative of adolescent depression as the more classical symptoms. In an adult, depression is more often clearly seen and interpreted correctly as such by both the physician and the patient and is useful clinically in judging self-destruction potential. We have learned to recognize that the depressed patient who suddenly loses his depressive symptoms may be at peace with himself because he has determined to die and is no longer in conflict about this decision. But a self-destructive attempt by an adolescent may come as a surprise to the family and physician who did not recognize the depression which the adolescent could not mention.

Impulsivity

Impulsivity is characteristic of the adolescent suicide. Self-destructive acts are usually not well thought out and may represent a whim on the

part of the adolescent. As pointed out by Gould (1965) this impulsivity often is the determining factor in the lethality of the suicide attempt of the adolescent; that is, unplanned and poorly executed attempts may result in a high number of "accidental suicides." But on the other hand, an inexpert or imperfect knowledge of lethal methods makes the likelihood of successfully completed suicides less certain. Adult suicide can be an impulsive act as well, but a determination to end life seems more characteristic of adults. In completed adult suicides, methods of high lethality are often chosen with careful planning and much forethought before the attempt. There is apt to be more rumination about suicide over a longer period of time in the adult than in the adolescent. I think, as an illustration of this, one might consider suicide by automobile. Adolescents and adults both attempt suicide by automobile. We can speculate that in the adolescent such suicide may be very impulsive and related to a sudden whim to turn the wheel, whereas an adult suicide by automobile may more frequently represent a deliberate attempt to cover up the suicide for insurance purposes or other personal reasons such as sparing the feelings of the family.

Interpersonal Relationships

Although we have described adolescent suicide attempts as a result of progressive alienation from the family, one has to remember that we are referring to emotional alienation. Suicidal behavior on the part of adolescents may take place in the house with parents and friends in the next room. The attempt may be used to effect changes in the relationships within the family, to get back at the family, or as a reaction to the threat of loss of love. The adolescent attempt often is precipitated by a seemingly trivial event such as an argument over an exam mark or bed time.

Younger adult self-destructive acts may be similar to the adolescents but are most often a reaction to failure in marriage, work, or parenthood. Older adults suicide in the setting of waning abilities, sickness, or loss of a supporting environment. A precipitating cause may be less obvious, and the suicide may appear to be a reaction to a total life situation more than to a single event. Adult suicidal behavior may be a secret affair and rarely occurs in a family setting.

Similarities

There are some aspects of self-destructive behavior which do not seem to be differentiated by age. For example, females attempt suicide three times more often than males, whereas males complete suicide three times more often than females.

Males at all ages who exhibit suicidal behavior seem to be more ill psychologically than are females. Explanations for this seem to be related to sociocultural factors. Our society judges male and female behavior differently in regards to expression of aggression. Because there are adequate approved outlets for aggression by males they are less apt to turn aggression in upon themselves and therefore less apt to make trivial attempts. The expression of aggression in females is frustrated, resulting in a greater number of attempts at suicide. For a male to turn aggression in upon himself represents a more severe state of psychological decompensation.

Males, by and large, favor lethal "masculine" methods such as firearms or hanging.

Method of attempt may well be more related to culturally determined sex roles than to any age factor.

TREATMENT IMPLICATIONS

Adolescent Treatment

The adolescent suicide most frequently takes place in the context of family problems and often is directed at bringing about a resolution of these problems. The attempt often has the opposite effect, however, and further alienates the adolescent from the source of supportive gratification that he is trying to reach. However, it seems extremely important to involve the family in the treatment process from the very beginning. One particularly tries to get the family to help in the process of reversing the alienation of the adolescent. In a followup study of adolescent suicide attempters who had been hospitalized (Barter, 1967), we observed that those adolescents who had sustained a real or threatened parent loss, who lived alone after hospitalization, and who had poor social relationships had a greater likelihood of continued suicidal behavior and represented in essence a high-risk population.

Because a suicidal adolescent often does not appear to be terribly ill, his plea for help may be ignored.

The first attempt should be taken seriously and not passed off as a gesture or attention-seeking device, which leads to lowered self-esteem and a higher likelihood of further suicidal behavior, possibly lethal. Do not reassure a suicidal adolescent falsely that everything is going to be all right. Make an honest attempt to understand the agony the patient is going through. It does not pay to be sarcastic or to use techniques which essentially diminish the patient's self-esteem and further increase his suicide-proneness.

It is my feeling that adolescents who make self-destructive attempts should be hospitalized much more frequently than they are. In the study alluded to before, most of these adolescents made more than one attempt prior to the attempt which led to their hospitalization. The hospitalization serves to remove the adolescent from the stressful situation and allows both the patient and the family to reconstitute to an extent. The patient feels supported, protected, and cared for.

Discharging the adolescent from the hospital before he is ready to go or before significant changes have been brought about in the family increases the risk of further suicidal behavior. Antidepressive medications can be used with the suicidal adolescent. However, I feel that such medications have a much more prominent role in the treatment of the depressed suicidal adult. When one is dealing with a suicidal patient, any therapeutic modality which has potential usefulness should not be overlooked, including, of course, drug therapy.

Finally, I would like to say a few words about the problem of suicide prevention in adolescents and in adults. It is important to remember that the suicidal adult is apt to seek professional help, as contrasted with the suicidal adolescent who often feels help is not available and who makes the suicide attempt in an effort to involve his family. The physician is apt to be involved rather late in the game, frequently after the adolescent has made more than one suicide attempt. It seems to me that in many ways we have an understanding of the warning signals and danger signs in the adult suicidal patient. We have been able to identify those factors which seem to increase the risk of lethality, and we can readily set up suicide prevention services on a rather rational basis.

I do not believe that we have as good criteria for assessing suicidal potential in the adolescent nor for picking up the suicide-prone adolescent. Teicher and Jacobs (1966) had stated that they do not believe that the physician can distinguish a potentially suicidal adolescent from other adolescents. First attempts at suicide among adolescents come as a great surprise to parents and friends, as well as physicians involved with adolescents.

I feel we have to be thankful that the great majority of adolescent suicidal attempts are of low lethality. We must recognize that we have a greater responsibility for heeding the cry for help represented by the first suicide attempt of the adolescent and not placing him in a position where he has to make repeated attempts in order to gain the help that he needs. It is particularly important to educate families and family physicians not to ignore self-destructive behavior in the adolescent but to treat self-destructive attempts as a plea for help which, if denied, will lead to further acting-out of suicidal behavior.

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TWO TYPES OF SUICIDAL BEHAVIOR

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INTRODUCTION

This paper attempts to identify and to discuss treatment plans for two types of suicidal patients seen in clinical psychotherapeutic practice—the interpersonal and intrapersonal types. Experience at the Los Angeles Suicide Prevention Center and with other helping institutions and individuals indicates that most suicidal situations will tend to fall into one of these groups. Therefore, an understanding of the clues to their identification and general treatment procedures for them should help significantly in the overall program of suicide evaluation and treatment.

There is little need at this point to go into great detail regarding the enormity of the suicidal problem in the United States. One might briefly point to the great loss of life (suicide is generally considered the number 10 killer in the United States), the depressing and malignant effect on those surrounding the suicide attempter, and the primary fact which is that the suicidal action is an indication of great emotional distress in the individual.

SOME DEFINITIONS AND CLARIFICATIONS

Before delineating the two clinical syndromes referred to above, it may prove valuable to spend some time defining and clarifying certain aspects of suicidal and self-destructive behavior. Suicidal behaviors are found in that relatively limited group of individuals who have conscious intimations of doing away with themselves and proceed to act on these intimations. Self-destructive behavior deals with a much broader range of activity that tends to shorten the physical life of the individual, including such diverse activities as accident, dangerous vocations, dangerous avocations, addiction to drugs, and a number of other categories. Suicidal behavior is included but as only one category among many. Self-destructive activities are often found to coexist with suicidal activities, but the relationship is not an inevitable one. Indeed, there are probably a number of different types of relationships.[1]

There are a number of significant differences between suicide attempts and completed suicides. First is the comparative number; there are at least six times as many suicide attempts as completed suicides. It is, of course, difficult to secure an accurate indication of attempted suicides since in most areas there have been no legal or other provisions made for recording all suicide attempts. In addition, even if such provisions are made, it is doubtful that all people making suicide attempts would cooperate in the reporting procedure. Many suicidal attempts (particularly those which do not result in severe incapacity to the individual) can easily be concealed and, for a number of reasons, concealment is exactly what the suicide attempter wishes to accomplish. However, there have been a number of efforts to estimate suicide attempts, and it is from these that the figure listed above is taken.

One's first impression may be that suicidal behavior has but one intention, and that is the cessation of life for the victim. It becomes evident, however, that a number of intentions are possible.

[1] "Theories of Self-Destruction," by Norman Tabachnick, Karen Kloes, Phillipa Poze, and Elaine Fielder, was presented at the 1968 Annual Meeting of the American Psychiatric Association.

Frequently more than one intention can be inferred from a study of the conscious and unconscious thinking of the individual. The intentions include the following: (*a*) A wish for relief from anxiety; (*b*) a wish to be reborn; (*c*) a wish to communicate a need for help; (*d*) a wish to punish oneself; (*e*) a wish to punish someone else; and (*f*) a wish to enjoy approaching death which is eroticized.

Most suicide attempts occur in a context of communication. This is because the intention to die is almost always accompanied by an intention to live. The strength of these intentions varies in different individuals, but both are usually present. It is because the individual wishes to live that the suicide attempt is most often made in such a way that someone else learns about the suicide attempter's activity and the distress which lies behind it.

An important question in suicidal attempts is: How lethal was the attempt? How does one assess this aspect? In general terms, one could and should use the evidence of how close the person actually came to killing himself. Thus, if he was in a state of coma for several days, one can be sure that he was dealing with an extremely lethal attempt, whereas if no physical disability was noted, the attempt can be judged as mild.

Yet it may be possible to make a more accurate assessment of lethality. This might be done by applying two methods of evaluation to the suicidal behavior:

The Point of No Return. This factor refers to the speed of the suicidal mode utilized. Examples of extremes in this situation would be a .38 calibre bullet fired pointblank at one's heart. (This would have a point of no return of less than 1 second.) Contrast this with the ingestion of 15 Seconal capsules (this would have a point of no return of approximately 8–12 hours).

The Possibility of Rescue. This factor refers to the physical and social possibilities for rescue surrounding the suicidal attempt. There are good possibilities for rescue of a housewife who swallows several barbiturate capsules approximately 1 hour before her husband is scheduled to come home from work. On the other hand, there would be poor possibility of rescue for an individual who told his friends that he was going away for the weekend, then, on leaving them Friday evening, went directly to his home, took 40 barbiturate capsules, and locked himself into a closet.

THE TWO GROUPS OF SUICIDE ATTEMPTERS

After this general description of certain aspects of the suicidal situation, let us move to the characterization of the two important clinical groups already referred to. Let us call them the interpersonal and the intrapersonal groups.

The Interpersonal Group

1. This type of suicide attempter tends to be neurotic.
2. The age group is a relatively young one, ranging from 16 to 35 years.
3. The majority of these attempters are women.
4. They are usually quite involved with other people.
5. They are often at odds with other people, and their suicide attempts reflect a difficulty they are having with a significant other.
6. Their attempts tend to have a fairly low lethality.
7. They generally respond well to attempts by others to help them.

The Intrapersonal Group

1. There tend to be many more psychotic or borderline diagnoses in this category.
2. They fall into a much older age group than the interpersonal attempters. They are usually 50 years of age or older.
3. There are many more men than women in this group.
4. These people tend to be isolated. They have typically encountered a progressive loss of significant esteem-sustaining objects such as jobs, significant other people, good health, etc.
5. There are extreme self-punitive and self-depreciating feelings. These include attitudes of depression and disgust about the self. In general, their self-esteem is quite low.
6. This group of individuals tends to have a relatively high lethality rating in their suicide attempts.
7. They respond relatively poorly to helping activities.

The intrapersonal group is obviously the more serious one. Comparison with individuals who have completed suicide indicates that the intrapersonal group of attempters may be a precursor group to those who have successful suicidal activity.

DANGER SIGNS AND CLUES

There are a number of important diagnostic criteria which are noted in these groups.

Manifestations Characteristic of Both Groups

1. Depression (of almost any kind).
2. Drinking and drug-taking.

Drinking and drug-taking are significant in suicidal people from a number of standpoints. First of all, the very fact of the ingestion of alcohol or other drugs is an indication of lowered reserves of self-esteem in the victim. Secondly, having once taken drugs or alcohol, the individual's ability to organize and integrate his behavior according to self-preservative standards is impaired. Thus, whatever his situation before ingestion, the possibilities of self-destructive behavior are increased after ingestion.

Symptomatology Characteristic of the Interpersonal Group

1. There are frequently suicidal threats, suicidal actions, and intimations of suicidal behavior which occur in interpersonal settings.
2. There are often emotional outbursts.
3. A history of previous suicidal behavior is frequently obtained.
4. The suicide plan which members of this group possess is usually not well defined. Often there is no plan apart from an intention that, if things continue to go badly, some kind of suicidal activity will take place.
5. "Interpersonal attempters" often have very clear and definite ideas as to how their crisis may be easily ended. They may sometimes be reticent in terms of quickly entering into discussion with the helper, but once a bond of trust and confidence has been established, the thought as to what might terminate the emotional crisis is easily forthcoming.

Specific Symptomatology Characteristic of the Intrapersonal Group

1. There is noted in the history a progressive isolation from significant others and from valuable outside situations.
2. Opposed to the "interpersonal" group, the suicidal thoughts and activities of this group of individuals are usually concealed.
3. They tend to have well thought out suicidal plans and have made preparations to implement them.
4. They are almost invariably depressed but, interestingly enough (and perhaps related to the lack of "significant others" in their lives), they have not communicated their depression to others.
5. They are relatively hopeless, quick "bounce-backs" are rarely seen, and they generally have few or no ideas of how their situation might be helped.

THE CAUSES OF SUICIDE

The etiology and predisposing causes of suicide have been discussed at great length in many books and articles. Obviously, a short paper such as this cannot hope to do justice to the many worthwhile contributions. However, from the standpoint of the clinic, suicide can be related to an extremely important duality of causes.

The first factor is that there is almost always a real external trauma or loss. This loss can take many forms. It may involve the death of a loved one, the threatened or fantasied departure of a loved one, the loss of a job, the loss of good health, and many other factors. What I emphasize is that some *real* loss may be identified in almost every suicidal situation.

Secondly, there is almost invariably an internal loss (of hope). This loss complements the external loss and is often accompanied by a disorganization of the personality.

These two factors are found to a greater or lesser degree in practically every suicidal situation. An attempt should be made to identify the specific aspects of each of these factors as a first step in the treatment of a suicidal individual.

THE TREATMENT OF SUICIDE

Coinciding with the formulation of the dual causation of suicide, the treatment of suicide is directed to two concurrent aims. These are the reintegration of the personality and the restoration of hope and objects.

The Reintegration of the Personality

As already stated, there is some degree of disorganization of the personality in every suicidal person. This is reflected by a lack of clear judgment. Often there is an aimless skittering about of the mind. It first latches onto one possible direction for action, but before this can be followed through or indeed even clearly delineated, it quickly moves on to another one. There is a difficulty in organizing an appropriate hierarchy of values. The simple question "Is it more important to go into the hospital following a near-lethal suicide attempt or to be at home because the repairman for the washing machine is coming?" is often difficult to evaluate for a suicidal person. Other indications of poor judgment abound.

To deal with such a situation, the counselor must be encouraging, supportive, and friendly to the victim. However, more than this is required. After establishing himself as a useful, valuable, and authoritative friend, there should be no hesitation in taking over the task of making important judgments when it seems that the suicidal patient cannot accomplish this task himself.

Furthermore, in the course of making these judgments, the counselor must be logical. He should be able to organize a hierarchy of situations to be acted upon. He must be able to say what should be done first and what can wait until a later time because it is not so important. In the course of doing this, he not only helps the suicide attempter make certain decisions which might be quite helpful and indeed life-preserving for him, but, equally important, he shows the victim how "appropriate" thinking proceeds. The treatment of the victim in this way acts as a learning experience. Many victims utilize such activity of the therapist as a model upon which to base present and future activities of their own.

The Restoration of Hope and Objects

The basic aim of restoring hope and objects should be implemented in both the interpersonal and intrapersonal groups. However, certain differences in the two groups call for somewhat different techniques of implementation.

The Interpersonal Group. Since the separation from the significant other person or institution is often, in fact, one that can be repaired relatively easily, a first aim of the therapist is to see if this can be done. He must evaluate the seriousness of the rupture with the significant other situation or person by talking to both the suicide attempter and the other person. In addition, the emotional support which is freely given in the situation tends to act as an important nutrient for the depleted suicide attempter. He "swallows this in" and, in the process, becomes stronger.

The Intrapersonal Group. Emotional support is the keystone of the treatment of suicide. This means that it must be given freely and in great quantities to all suicide attempters.

To restore lost objects is not as easy in this group of attempters as it is in the interpersonal group. This is because reality considerations often make the objects impossible to restore. Suicide attempts here often occur in response to recent or past losses of spouse, children, or important friends. These people may be irrevocably lost. When an older person loses a job or his good health, it is often difficult if not impossible to restore them.

However, one can attempt to find new objects which can replace the lost ones. From this standpoint, moving toward new interpersonal relationships, new occupations, new avocations are all an important part of the therapeutic handling of attempters in this group.

It will be sensed by this time that the treatment of the "intrapersonal" group will likely be more prolonged and often need to be more intensive than of the "interpersonal" group. One must recognize this at the beginning and be prepared for longer, more drawn out therapy. If one is willing and able

to provide this therapy, gratifying results will often ensue. Perhaps one important reason for this is that by providing such help to the troubled individuals, the therapist himself becomes a replacement for those lost objects which brought on the difficulty.

In conclusion, it is much easier to write a paper about therapy than to conduct therapy. In order to make certain points in what I hope has been a clear way, I have necessarily had to simplify and codify a complex and difficult situation. It goes almost without saying that there are many suicidal situations which need and deserve a more elaborate evaluation than I was able to indicate in this paper. However, the attempt has been to provide certain guideposts that can act as an initial orientation to the treatment of suicidal patients.

PLANNING FOR SUICIDE PREVENTION

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That suicide is a growing and serious public health problem you are quite aware. That is why you are here. It is intolerable, however, that we should continue merely to react to isolated examples of the problem or, worse, utilize cultural taboos which, in effect, permit us to deny that there even is a problem. We can no longer allow ourselves to get caught in rational manipulations of a philisophical nature over the rights of a person to kill himself. The goal of suicide prevention, after all, is not to so constrain a suicidal person that he cannot commit suicide if he wishes, but rather to help him regain perspective, perceive alternatives, and reestablish meaningful relationships.

This goal of finding alternatives to death proceeds conceptually from the hypotheses of Shneidman, Farberow, Litman, and others who postulate that there is a fundamental ambivalence to be found in most persons who commit or attempt suicide. On the one hand there is the wish to escape pain and isolation through death and, on the other, the desire to find satisfaction and gratification through living. The extent to which this ambivalence is present in all completed or attempted suicides remains a question.

Community and professional response to the opportunities presented by this ambivalence is, however, not purely humanitarian in origin, or motivated solely out of the need to help people. Suicide is a very costly action. It is costly first of all in terms of the human suffering and deprivation which so often accompany it. There are additionally the lost skills and the unearned dollars no longer available to the society, and there are the welfare dollars which often must be used to provide for the survivors. Perhaps the most expensive factor—and we know little about this facet of the problem—is the psychological damage done and the future pathology initiated, especially where children are involved. From the perspective of the public health, suicides are costly—psychologically, socially, and economically. The discipline of public health provides structure and strategy for combatting disease under endemic and epidemic conditions, and this structure may provide us some guidelines in our planning for suicide prevention. Most of you are public health officers and, as you well know, adolescent suicide within the Northern Cheyenne tribe often reaches epidemic proportions.

SUICIDE PREVENTION PROGRAMS IN THE UNITED STATES

Programs specifically related to suicide prevention at present function for the most part in the tertiary stage of the public health model, and there is considerable activity throughout the United States in providing such services and planning for such programs. In the spring of 1968 there were over 70 suicide prevention programs located in 23 States and the District of Columbia. An analysis of these programs may provide ideas and structures which can be useful in the local situation.

These 70 suicide prevention programs vary greatly in program goals, administrative structure, fiscal solvency, community investment, and the extent and manner in which professional mental health workers are involved. Most of them grew out of the concern of small groups of citizens made up usually of physicians, psychiatrists, psychologists, clergy, social workers, teachers, etc. Most of the groups have made a considerable in-

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vestment of time to work through the community organization process so essential for the operation of this type of service, for the effectiveness of these programs is in almost direct ratio to their lines of communication with the various helping resources in the community.

Although all the programs perceive suicide prevention as one of their goals, most do not limit themselves solely to this area, but describe their program so as to encompass the broader field of crisis intervention. Most of them have some kind of relationship or understanding with at least one general hospital, and usually with a psychiatric inpatient facility as well. Severe emergencies of an outpatient nature are covered through arrangements with mental health clinics, social agencies, etc., who agree to take referrals on a next-day basis when so requested. Some of these suicide prevention programs have worked out effective feedback methods for the followup of referrals and for secondary referral where the initial referral is partial or temporary. These suicide prevention agencies in some cases have been the catalyst leading to the establishment of community mental health centers, and all community mental health centers should eventually provide the skills and services presently offered by many suicide prevention programs.

The question is often asked as to the unique features of these suicide prevention services. What do they offer that is not already being offered in many communities?

In considering this question of uniqueness, perhaps we should make clear that the answer reflects the intent, if not in every case the reality, of these services. Spread over much of the United States, these varied and assorted programs have developed goals and objectives which, in theory if not completely in practice, add a considerable dimension to man's reasoned response to another man's cry for help.

GOALS AND OBJECTIVES OF SUICIDE PREVENTION PROGRAMS

The uniqueness of these programs can best be pinpointed through a simple brief summary of their goals and objectives; namely, "availability to people in crisis." It is precisely the unrestricted nature of this objective which indicates the unique, innovative, and truly exciting aspects of these services wherein we find a concentrated effort to respond to a human in crisis and to deal with the fact that most human crises do not break down nicely and cleanly into medical, psychiatric, or social emergencies, but rather combinations and permutations of all three. These suicide prevention programs—crisis centers, emergency centers—have in common at least two operational principles. The first is that someone should be available to persons in crisis. Now by availability, they don't mean 8 a.m. to 5 p.m. on weekdays. They mean 24 hours a day, 7 days a week, 365 days a year. This in itself is a heavy burden to undertake and a new dimension of helping outside of the strictly medical tradition. The second principle is that the someone who is available should be able to respond to the person in crisis with competency and resourcefulness. Now you will notice that no effort is made to spell out, to define or restrict, the kind of crisis that will be handled. There is no limiting the crisis to medical crisis, or psychiatric crisis, or social crisis. The response is to the person who is calling for help, rather than to some fractioned aspect of that person's life.

Suicide prevention-crisis centers therefore function as a kind of general emergency answering and referral service. This intake service is focused not upon any particular substantive area of emergency such as psychiatric, medical, or social, but rather upon the person having the emergency. This is an important distinction.

Consciously or not, the leaders of this movement have acted so as to correct some serious deficiencies in the way communities in the United States provide emergency assistance. The planners of the community mental health center programs were concerned with certain aspects of these deficiencies; for basic to the concept of the centers program is the responsibility to provide an integrated, unified, coordinated resource to all persons—from a stated geographical area—needing help because of mental illness. Suicide prevention programs are sometimes accused of overextending themselves, but they have a refreshing willingness to assume at least limited responsibility for obtaining proper and appropriate assistance for a person in crisis.

Availability

Conceptually this type of emergency service provides two components: (*a*) Availability and, to

a lesser extent, (*b*) accessibility. These are important components. Ideally, the person calling immediately finds sensitive, knowledgeable assistance 24 hours a day, 365 days a year. This is availability. The community obtains a coordinating, enabling facility which assumes responsibility for getting people in a crisis to appropriate help. The very nature of the telephone service and its widespread use throughout the United States provides a considerable degree of availability.

A telephone answering and referral service does not, however, provide complete availability. There are numbers of persons who do not consider the telephone a natural extension of their right arm. Also, many people do not have a telephone, or, if they have one, are geographically remote from the help to which they might be referred. This limits the accessibility component. But a telephone answering-referral service is a tremendous step, an important element in coordinated, adequate, and immediate response to people in crisis. One vital question which each of you faces is how to provide some equivalent for the telephone's availability.

Telephones on the reservation, I'm sure, are relatively few and far between. What other modes of communication are available and how can these be utilized? Can you tie into any systems which are in communication with many of the people you might wish to know about? In some parts of the South the gas station at the crossroads is the focus of community communication. Agricultural agents in rural areas come into contact with many otherwise ignored persons. The rural mailman goes throughout the entire community. On the reservation the PHS hospital is, in a sense, the GP, but in many localities he is most knowledgeable about isolated persons and families. Don't overlook the political structure. Often the local block captain, ward boss, or rural equivalent, is in communication with great numbers of persons.

Accessibility

Accessibility of services is the effort of the helper to reduce all barriers to communication between himself and someone needing help. There are many kinds of barriers to effective communication: physical, geographical, social, religious, cultural, and psychological, to name the most obvious. Accessibility is the process placing the helping service out close to where the action is—where the need is.

At the Lincoln Hospital in New York City, Harris Peck, M.D., and his associates are attempting to reduce many barriers. Some of you are familiar with the neighborhood centers Dr. Peck has set up to "provide more adequate mental health services to the poor." What are some of the barriers to communication which he is attempting to overcome? Well, first of all Peck specifies that there must be "neighborhood" centers. For physical, geographical, and psychological reasons it is necessary in many urban slums to place services as closely as possible to the population in need. These people are often overwhelmed by physical size and even minimal geographical distances.

The strangeness and size of a medical-hospital building is frightening and hostile. A distance of 10 or 15 blocks may be prohibitive in terms of cost, strangeness, leaving children alone, and uncertainty as to what is to be accomplished. A walk-in service, immediately available in a store front type of building, can reduce many of the barriers to initial communication. Immediate response, a familiar type of building, a short period of time away from home, a familiar locality, and no cost incurred, all of these factors combine to reduce fear and suspicion.

Dr. Peck is working extensively with indigenous mental health aides in order to further reduce the barriers to communication. These aides, he suggests, if adequately trained for specific roles and tasks can communicate much more effectively, and with much more empathy and identification, than middle-class professionals. A high percentage of those who come to these neighborhood centers seek help with immediate problems—welfare, housing, unemployment, family relationship, adjustment of children in school. They are in crisis and need competent knowledge and assistance. A high percentage of these crises are not immediately psychiatric in nature. When psychiatric consultation and expertise seems indicated, it is available both in the neighborhood center and, much more elaborately, at Lincoln Hospital itself.

This is an example of what is meant by accessibility of services: the modification, extension, decentralization, adaptation of psychiatric and psychological skills and services in order to reduce communication barriers between the someone "out there" in need of help and the helper "in here." Do the efforts of Dr. Peck suggest any innovations which might be applied to the reservation? Sometimes accessibility can be accomplished only by

sensitizing groups already in communication with a community. This takes time, skill, patience, and sensitivity, but it need not be very expensive. The programs in North Carolina are illustrative of this approach.

The Halifax County Program. In a paper shortly to be published in the *Community Mental Health Journal*, Eisdorfer, Altrocchi, and Young describe a part-time program carried out by consultants from Duke University. Halifax County in north central North Carolina is considered to be a borderline poverty area with a mean income per family of about $3,000/year. Seven hundred and seventy-two square miles in size, with a population of approximately 60,000, it is essentially rural. This program of part-time consultation has been going on for about 8 years. The consultant at first began to visit the county for two or three 1-day visits every month, working with key care givers, school superintendents, the public health nurses, the county medical offices, the county welfare directors, the leaders of the ministerial association, etc. Group consultations were instituted rather than individual consultations, although the consultants worked with health directors to handle a limited number of emergencies which arose in the community.

Within a short time, demand for clinical services required further consultation by a psychiatric resident 2 days per month. His consultation around severe clinical problems was more directly with the county physicians and on a one-to-one basis. By the second year, the program, considered to be successful by the criteria of community acceptance and participation, was supported by the county commissioners. Consultation was expanded to the police department, and consultants began to make visits directly to schools. Consultants were able to help the county on several issues: segregation, mental retardation, illegitimacy, etc. A serious problem of suicide was identified early, but it was some time before community interest was evoked to the point that an effective and sustained emergency program related to suicide prevention could be established. A countywide committee undertook responsibility for organizing and staffing this program; the consultants acted as resource people and provided consultation to the lay staff.

The authors of the above-mentioned paper, *Principles of Community Mental Health in a Rural Setting: The Halifax County Program*,[1] list 20 principles. Principle 20, interestingly enough, reads: "The most appropriate attitude of the consultant is one of eagerness to learn from the community." Enough two-way learning (the work of true consultation) took place over an 8-year period to enable this poverty-ridden rural area, suspicious of mental health workers and health workers, to submit recently a proposal for a County Community Mental Health Center.

A Five-County Rural Project. In western North Carolina, another type of consultation has been going on for several years. Dr. James L. Cathell, the State Mental Health Department's Psychiatrist consultant to local physicians, has concentrated on a five-county rural area populated by 140,000 and served by 68 physicians, none of them psychiatrists. Sixty-four of them have been participating in a pilot project in which once or twice a month Dr. Cathell is on call to help handle emergencies.

But to a surprising extent, the project has been able to mobilize community services in support of the project. Over a 2-year period, admission rates from the five-county area dropped 25 percent, but the real value, in Dr. Cathell's opinion, is the impact the program has on mild psychiatric illness through the modification of attitudes on the part of the physicians and the families involved. Dr. Cathell has special accessibility through the public health nurses serving the area who, over a year's time, visit every family in the area.

Recently Dr. Cathell turned over this going consultation program to two other psychiatrists. He is going to try to implement a similar program in the destitute eastern area of the State. "I'll probably do nothing but drink coffee the first 3 months," he recently told a staff member of the CSSP. He believes the success of the project could be duplicated anywhere—with the possible exception of the largest cities. But, he adds, "The consultant has to be flexible. He should be alert to ways—even unconventional ways—to use the resources the community offers."

I wish that I could now detail a suicide intervention program specifically tailored to the situation on your Indian reservations. But, just as I'm sure no two Indian reservations are alike, so

[1] Vol. IV, No. 3, June 1968. pp. 211–220.

too no suicide or crisis intervention programs can be exactly similar and I, least of all, could begin to construct a program. Only you who are most aware of the difficulties, the realities, the strengths, and the resources of your own situation can begin this task.

Hopefully this presentation will have clarified your goals and objectives, and perhaps suggested some conceptual and organizational ideas to build on. In the final analysis your problem is the same as that faced by anyone who attempts to help people in crisis or in an emergency: How can I hear their cry for help? How can I respond quickly, appropriately, and helpfully?

One thought in conclusion: There is no magic here but rather hard work, skill, patience, thoughtful planning, and conviction. All of the programs discussed recognize and exploit a very basic principle in human dynamics. As you reach out to people and get close to them, most will respond. He who reaches and he who grabs hold are both richer for the experience.

MENTAL HEALTH SERVICES IN A SPARSELY POPULATED AREA:

A Necessary Complement to a Suicide Prevention Program

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The primary goal of a suicide prevention program is to save lives. There be other goals, but this is the primary one. By their very nature, suicide prevention programs focus upon individuals who, for one reason or another, have become unhappy and dissatisfied enough to find life not worth living. With varying degrees of intentionality and awareness, these individuals have moved closer to taking their own lives as the ultimate solution to their problems. Shneidman and others have documented in convincing manner that in most cases this contemplated final solution is ambivalently arrived at after the individual has tried in vain to communicate his hopelessness and need for help to others. Both society and the individual himself usually view suicide as a last-resort solution taken from a position of hopelessness and despair of finding more adequate solutions.

Most often mental health professionals come into contact with individuals who have been unable to govern their behavior so that it is socially productive and acceptable. Mental health services, in a basic sense, are oriented toward helping individuals achieve meaningful lives, acceptable to them and to the society in which they live, when they have been unable to do so because of vicissitudes in developmental and socialization processes.

Basic helping agencies and individuals informed about suicide and the "cries for help" of the potential suicide must be available in a community if a suicide prevention program is to be effective and successful over the long run. From one perspective, the need for a suicide prevention program focusing upon crisis intervention is a sad commentary upon the effectiveness of the more primary helping agencies and individuals in the community.

Suicide prevention programs not only help in crises experienced by individuals; they also serve as a distress sign to the rest of society showing that here is a problem area that needs attention. To be effective in their long-range goals, they must maintain a close liaison with other agencies and caregivers within the community. They cannot operate effectively in isolation. To do so would only result in one more isolated service, albeit a needed one, in a community of services already badly fragmented. As important as the crisis intervention aspects of a suicide prevention program are, its liaison activities with other community caregivers and agencies are just as essential.

It is not coincidental that concerns over suicide and concerns over mental illness are developing simultaneously. Although potential suicides are not always mentally ill, they are unhappy and disturbed individuals. Potential suicides are or should be the concern of those working for better mental health and optimal human functioning. Mental health specialists must, and to an increasing extent are, assuming responsibility for providing appropriate help to the potential suicide and his family. The key word here is "appropriate help," and this does not necessarily mean direct service to the individual. As often as not, it may mean indirect service through consultation to frontline caregivers who will actually work directly with the potential suicide and his family. This point will be elaborated upon later. The important aspect at this time is that because of the very nature of the problem involved, suicide prevention programs and mental health resources and specialists must work together to cope effectively with the problem.

Aroused national concern over mental health problems during the past decade reflected both irritation with ineffective past practices and renewed hope for better programs with the advent of newly developed treatment procedures, especially the drug therapies and group therapies. Congress provided Federal monies for construction

and staffing of comprehensive community mental health centers, and this represents the translation of national concern into mechanisms for action. This program has come to be known as the comprehensive community mental health center movement. Its primary purpose is to make appropriate mental health services available and accessible to individuals in their own communities at the time they need them. Key concepts involved are continuity of care, accessibility of care, community involvement, comprehensive range of relevant services, and responsibility for a definite geographical service area. Before elaborating upon this program, however, and its relevance for sparsely populated areas and suicide prevention programs, the program must be put in proper perspective.

Mental health services in a community are not synonymous with a comprehensive community mental health center. The comprehensive center in a community may be a central focus and resource for mental health services, both direct and indirect, but it is not the only source of competent help for mental health problems. Other caregivers and agencies in a community can be, and often are, trained to provide many kinds of help with mental health problems. These include physicians, pastors, teachers, nurses, caseworkers, law-enforcement officers, rehabilitation counselors, school psychologists, and many others.

The mental health center is a resource providing direct diagnosis and treatment in some cases, indirect consultation and education services at other times, and serving as a catalyst for mounting prevention programs in still other instances. It is an increasingly necessary part of the network of helping services in a community. But the mental health of a community continues to be influenced as much, if not more, by the adequacy and effectiveness of the fundamental programs and services offered by schools, churches, welfare departments, health departments, courts, and so on. The situation is similar to that found in health and in education. Community health is as much influenced by technological devices for the control of air pollution and by indoor plumbing as by direct services provided by physicians. And although the schools have a formal responsibility for providing certain kinds of learning, educational experiences take place outside the school, in the home, church, and elsewhere.

The importance of frontline caregivers, especially in a sparsely populated area, cannot be stressed too much. The role of the pastor and the family physician is perhaps most crucial. It is worth remembering that in 1960, Gurin, Veroff, and Feld, in their survey reported in *Americans View Their Mental Health*,[1] found that, of 345 individuals who reported having gone somewhere for help with a personal problem, 42 percent turned to their pastor and 29 percent to their physician. There is no evidence to the author's knowledge that this is inaccurate or that it has changed appreciably since the survey was conducted, although variations in the pattern do exist. Mental health specialists can, and should, relate to frontline generalists, such as pastors and physicians as much as to individuals in need of direct help. Indirect consultation services to generalists is an important aspect of the role of mental health specialists, especially in a rural area.

An important role of a mental health center, then, is to strengthen and help make more effective the work of such frontline professionals as physicians, teachers, and pastors. Now for a closer look at what a comprehensive community mental health center actually is. It is most of all a unifying organizational concept for providing an appropriate range of mental health services to individuals and communities when and where they need them. It is not to be confused with the traditional mental hygiene clinic, which characteristically is much less comprehensive in the scope of services it offers. As specified in Federal regulations, a comprehensive community mental health center, to be eligible for Federal funds, must have the following characteristics:

1. *A Specified Catchment Area.* A center must serve all individuals within a specified catchment area of no fewer than 75,000 or more than 200,000 people. In special cases where vast distances and sparsity of population are involved, a rural area can obtain a waiver to develop a center that would serve less than 75,000 population. The Northern Wyoming Mental Health Center obtained such a waiver to serve about 45,000 people. The basic rationale behind the catchment area regulation is to make mental health services geographically accessible to individuals in a unit of small enough size so that it can be responsive to local needs.

2. *Five Essential Services.* A center must, as a minimum, provide the following five essential elements of service: outpatient services, inpatient

[1] Gurin, Gerald; Veroff, Joseph; and Feld, Sheila. *Americans View Their Mental Health.* New York: Basic Books, Inc., 1960.

services, partial hospitalization services, emergency services, and consultation and education services. A center may also provide the following services in addition to the five essential ones: diagnostic services, rehabilitative services, precare and aftercare services, training, and research and evaluation. The concepts of continuity of care comprehensiveness of services are thus reflected in the basic five elements of service and encouraging additional services.

The requirement for five essential elements of service has been of special concern in many sparsely populated areas where some have felt that it is not feasible to mount such an array of services. The regulations are not as rigid as they might seem at first glance, however. To say that all five elements must be present is not to say that they will everywhere be present to the same degree. Several kinds of variation, depending largely upon how manpower and finances are allocated, are possible within the centers' concept, and it is to be expected that certain variations will be more commonly found in sparsely populated areas and other variations more commonly found in densely populated areas.

Few places will be found that are more sparsely populated than eastern Montana and northeastern Wyoming. Yet both of these areas have conceptualized programs including the five essential elements of service and have received Federal staffing grants. Because of the vast distances involved and the sparse population, the program will emphasize consultation and indirect services to frontline caregivers in the area. About 60 percent of the resources of the center is projected as going into the consultation and education area. Because of the vast size of the area, services will be decentralized to a large degree so that they will be more readily accessible. Several local hospitals at different locations within the region, for example, have contracted to provide emergency services and some inpatient services.

3. *Continuity of Care.* A center must provide for continuity of care within the elements of service it offers as well as with frontline caregivers in the area. As stated before, a center must provide the five essential elements of service. However, all five elements of service need not be under the same roof or in the same building. A common pattern, for example, especially in sparsely populated areas, is for several existing agencies to combine forces and through contractual agreements provide a comprehensive centers program. A mental hygiene clinic which traditionally offered outpatient and some consultation services might expand its consultation services, provide some partial hospitalization services, and contract with a local general hospital to provide inpatient services and emergency services. To help insure continuity of care, and to prevent patients from becoming caught in any gaps between elements, written assurance must be obtained from affiliating agencies that a patient admitted to one element of service will be admitted without delay to other elements of service if the need arises. In effect, admission to one element of service constitutes admission to the entire complex of services. Also, there must be free flow of records between elements of service, with records being available to all elements of service as the need arises.

On a different dimension, and one that has special importance for a sparsely populated area, a center must give assurance that a private practitioner can participate in treatment of his patient in the mental health center when this is found to be beneficial to the patient. A physician, for example, could make use of partial hospitalization services for a patient and plan with the center staff the patient's specific treatment program. Such cooperative patterns of service will go far to prevent a patient from losing contact with frontline caregivers, and to keep frontline professionals involved with the individuals they serve. Where such cooperative arrangements are lacking, there is the danger of a specific service becoming a dumping ground via referral.

4. *Administration and Personnel Standards.* A center must meet certain standards with respect to personnel. The law states: "The medical responsibility for each patient will be vested in a physician. Psychiatric consultation must be available on a continuing and regularly scheduled basis, not less than once weekly." Also, "The overall direction of a center may be carried out by a properly qualified member of any one of the mental health professions."

In order for a comprehensive mental health center to be a truly comprehensive community mental health center, there must be meaningful involvement of local citizens in the center. This can be accomplished several ways, and at several different levels. Looking again at Montana, local involvement is obtained very meaningfully and

directly by the governing role of regional mental health boards appointed by county commissioners. Each of the 17 counties in this region was asked to form an advisory group to help the commissioners and the Regional Mental Health Board representative keep informed of the needs and thinking of the citizens in the county with respect to mental health services. These advisory boards are already actively working with Dr. Winfield Wilder, Medical Director of the Center, to hold Worry Clinics in each county.

Now to return to the suicide prevention program. Where does the suicide prevention program fit in with the comprehensive community mental health center? There is no one answer to this as several patterns are possible. The suicide prevention program could be sponsored by an agency other than the mental health center and, through close liaison, make appropriate use of the mental health center as a resource in the area. The suicide prevention center might be sponsored and operated by another agency and, through contractual agreement, be a part of the mental health center. As such, it would probably be involved in at least two elements of service focusing on suicide prevention: emergency service and consultation. Or the suicide prevention program could be part of the services of a mental health clinic that expanded to become a mental health center without involvement of another agency. Many variations of relationship are possible between mental health centers and suicide prevention programs. The important point is that these programs be closely coordinated in a way that makes sense in the context of local resources and needs so that a full range of services to community and individuals is available regarding the problem of suicide.

There is yet another impelling reason for close liaison between suicide prevention programs and mental health center programs, indeed for close cooperation and coordination among all helping services in a community, especially in a sparsely populated area. This has to do with the very real manpower shortage in the helping professions. Actually, the current shortage may be a blessing in disguise in that it forces us to look closely at our programs and to think creatively in devising ways of carrying them out. On one level, it has belatedly sensitized us to the very real contribution that can be made by the indigenous nonprofessional, by the individual living in the area who, with some inservice training and backup consultation, can implement certain programs. Suicide prevention programs have made good use of such individuals in manning emergency services on telephones.

On another level, the shortage is forcing us to take a second look at how we deploy and use highly educated specialists. Increasingly there is a tendency to use mental health specialists in a consultative role to frontline professionals and caregivers, rather than scheduling their time wholly with one-to-one therapeutic relationships with patients. Not only should a mental health center be a resource in the community for disturbed individuals who have been contemplating or have attempted suicide, but it should also be a consultative-educational resource for the staff of the suicide prevention program itself.

Rare is the individual who has never questioned or doubted, however fleetingly, the value and meaning of his own life. Rarer still the person who has never experienced to some degree depression and despair. And rarer yet the person who has never needed help. It would be naive to expect mental health services and suicide prevention programs to provide cure-alls for such aspects of the human condition. They should, however, by working together in close liaison and by strengthening the basic frontline caregivers and institutions of our society, be able to take a giant step forward in preventing needless suffering and premature dying.

SUICIDE AND SELF-DESTRUCTIVE BEHAVIOR IN THE OGLALA SIOUX:

Some Clinical Aspects and Community Approaches

Carl Mindell, M.D., and Paul Stuart

This paper will discuss some of the experiences we are having with suicide in the Community Mental Health Program on the Pine Ridge Indian Reservation in South Dakota. We will report on some of our clinical findings, including some statistics for the fiscal year (1966–67), and then move on to some new areas we are beginning to investigate, and approaches we have evolved, aimed at getting more community involvement in dealing with the problem of suicidal patients in a predominantly rural area. Let us begin with a case history of a suicide attempt.

One evening in January 1967, Mary Charging Horse took all the tablets left in a bottle of phenobarbital. She was brought to the hospital the following morning and admitted.

Let us sketch in some background material here which is available. Mary is 18, the elder of two children, her brother being 13. They live with their parents outside of a reservation community, about 50 miles from the hospital. We know nothing about Mary's early history.

Around age 14, while going to boarding school, she ran away several times after being teased, was jailed for truancy, but refused to return to school. Her mother attempted to get her back, but Mary cried, and her mother decided she wouldn't force the issue. Thereafter, Mary stayed at home most of the time, helping around the house. She had little in common with the other girls who were in school. She was isolated from other people outside of her immediate family with the exception of an aunt and at times would think about her aunt as a second mother, or even as her real mother, and would go to her aunt with her troubles or worries. Her aunt was seen as an interested, helpful, caring person.

Let's stop here for a moment and consider what we have learned so far about Mary. Mary has been home for about 4 years, having dropped out of school at age 14. Her mother made an attempt to get her back but decided not to when Mary cried. Although this situation is not rare on the reservation, it is somewhat unusual. It reflects the cultural value of respecting the child as an equal, respecting her decision and valuing her autonomy, and an unwillingness on the mother's part to impose her decision on her daughter. It is unusual as regards the minimal effort on the parents' part to get her more involved with people.

We should consider several other possibilities. One is that Mary's behavior in staying at home and not going to school may reflect her mother's wishes. Also, on an interpersonal and intrapsychic level, Mary's mother may experience a great deal of guilt whenever she feels that she has deprived Mary in some way of what Mary wants. This guilt would interfere with the mother's attempts at consistency with Mary and might also be a lever used by Mary, although perhaps unwittingly, in her relationship with her mother. Mary also has become more involved with, and dependent for, the satisfaction of her needs, upon her immediate nuclear family, and one member of the extended family, than most girls her age. It may be then that, when Mary is faced with a stress, she has limited resources in terms of people to fall back upon for help, as compared with other people in her peer group. Also, of course, she has not developed the techniques for getting along with people that she might have had with more normal social interaction. This suggests a possible goal for preventive work with high-risk groups; namely, finding ways to expand the individual's resources in terms of finding a person or persons to be available for help in times of stress.

Now let's go back to our history of Mary's suicide attempt. In July 1966 Mary's aunt died suddenly following a gallbladder operation. Mary was very upset, crying a great deal. She was Catholic and now threw away her cross and vowed not to

go to church anymore. She felt strongly that she should die so that, somehow, she might be able to join her aunt. She seemed to brood a lot and cry a lot. Some time in early August 1966 she cut her wrists.

So we see, in looking at her relationships with people and institutions, Mary lost a very important person and then cut herself off from another resource—the church. Her interactions now are even more confined to her immediate family. Moreover, she is longing to be close to her aunt and has the vague idea that death could accomplish this.

At this point, then, in her life, she seems to have become more involved in an intense relationship with her mother in which Mary would be very sensitive to any slights. She felt frightened of being on her own and wanted to be cared for especially by her mother with whom she would be angry when this wasn't forthcoming. She felt as if her mother favored her younger brother and tried to meet his needs rather than hers. Also she felt that her father wasn't especially interested in her and that her brother wanted her out of the house. It was as if she could do nothing with her mother—and nothing without her mother.

During this time she had a recurrent dream in which she would be sitting in her aunt's home and her aunt came in and gave Mary some flowers. Then the aunt cried and left. Mary felt that her aunt, in the dream, wanted her to follow as the aunt left. The dream reflects her continued wish to hold onto her aunt, not to "allow" the loss.

On the night of the suicide attempt, relatives came over with some children who were noisy. Mary stayed to herself, and when they left she complained about them to her mother, who bawled her out. When her mother left the room, Mary went to the cupboard and ingested the available phenobarbital tablets. She said nothing about it, but at bedtime she said somewhat enigmatically to her mother, "I don't know if I'll see you." She went to sleep, and when she didn't awaken in the morning her mother brought her to the hospital.

Mary said later in the hospital that, at the time she was bawled out by her mother, she felt more than ever that her parents, especially her mother, did not care for her, that she wasn't an especially important part of the family, and that they were more interested in other relatives. At that point, she said, she wanted to die. Mary stayed in the hospital about 10 days venting a lot of anger toward everyone, including her mother. Finally she asked her mother to take her home, and her mother signed her out.

We should now ask ourselves several questions and attempt to answer them at least partially. First, let us ask what the suicide attempt seems to mean and what it accomplishes. Then we will briefly discuss evaluating the severity of a suicide attempt.

What does this suicide attempt mean and what does it accomplish? The following dynamics in Mary's case are not uncommon in other cases also:

1. Mary said that when she was bawled out she wanted to die. This was an ambivalent wish as she gave some indications to her mother of what she was doing. Probably, but not certainly, all wishes to die are accompanied by a wish to be rescued to live.

2. It was a means of dealing with strong feelings of helplessness and passivity. Mary saw herself as being abandoned by her mother. In taking the pills, Mary takes the active role, i.e., it is she who is abandoning her mother. Human beings have a strong urge to turn passive experiences into active ones. For example, watch a child's play after he's returned from the dentist.

3. Here we will mention some possible determinants of the suicide attempt related to masochism.

a. Most clearly, the suicide attempt is a defense against her murderous anger toward her mother. The anger is turned toward herself.

b. The suicide attempt functions in the service of maintaining the relationship with her mother. It functions to minimize the possibility of being left by her mother or of Mary's leaving secondary to her anger, or of harming her mother.

c. It forces her mother to show interest in caring for her, to focus her attention to Mary. In essence, it is a means of controlling the relationship.

d. Being hurt herself justifies her anger, and wish to hurt and tyrannize her mother (through expiation).

e. Lastly the suicide attempt contains the very early meaning of—"when I suffer I get close to mother (aunt)."

For purposes of making this discussion more general and complete, we will mention briefly some other dynamics of suicide reported by Hendin (5):

1. Death as retaliatory abandonment: this cor-

responds with our second category, turning a passive experience into an active one.

2. Death as a problem-solving device: death is seen as the solution: "If things get too bad I can always kill myself."

3. Death as retroflexed murder: a turning in of murderous impulses toward another.

4. Death as a reunion: here death is seen as the means of rejoining a dead loved person.

5. Death as a rebirth.

6. Death as a final act for those who see themselves already as dead.

7. Death as self-punishment.

How should Mary's suicide potential be evaluated? What is the likelihood that she would kill herself? In evaluating Mary's suicide potential we should consider the following:

1. Does she want to die? This is a very important question to ask and one that most of us may shy away from. We believe it is the most important single question to ask. Every person who is depressed should be asked if he is feeling so depressed that he would like to die and, then, if he feels like killing himself. The reason this question is not asked more frequently may be that we feel that to bring up such a possibility directly is to suggest it to the patient and thus to increase the likelihood of suicide. Also, it is not asked, possibly, because we would be uncomfortable with the answer. There is absolutely no evidence that asking this question is harmful. The therapeutic possibilities in talking about the patient's possible wish to die are great. If the patient denies wanting to kill himself, this is usually reliable (*8*), but with an obviously depressed patient this denial should be heard with benevolent skepticism.

2. If the person indicates that he wants to die, he should be asked how he has thought of killing himself. In general, the more concrete the plan the higher the suicide potential, and the more vague the plan the less the suicide potential.

3. Now for some general criteria.

   a. Age—the older the person, the greater is the possibility of suicide.

   b. Sex—the danger of a successful suicide is greater in men than women. However, women make more suicide attempts than men.

4. What are the patient's available resources? Does he have relatives and friends who are interested and available?

5. Another question which should be asked of a person who wants to kill himself is "What would happen if you died?" Meaning what would happen to the person and also to his family. This would give an understanding of what death means to the person and what it would solve (*4*).

We didn't have a chance to ask Mary all of these questions before her suicide attempt. We did, however, judge the severity of her suicide attempt. This is important to do not only for the obvious reason of evaluating further suicidal potential but because it seems likely that people who make mildly severe attempts may be significantly different from people who make severe attempts, and in thinking about intervention and preventive planning, these characteristics may prove important. We will suggest a scale of severity running from mild to moderate to severe. This should be judged according to three criteria:

1. *Method of suicide.* Some methods are more lethal than others. For example, in the United States, shooting and hanging are highly lethal while wrist-cutting is mildly lethal. An overdose may be in any category depending on the amount ingested. According to Mary's mother, there were not many pills left in the bottle, so that Mary took a small overdose and the method would be judged as mild.

2. *Intent.* Here we look at the purpose of the attempt. Is it to die (which would be severe), to gamble with one's life, where there is a chance of dying (*14*) (which would be judged moderate), or is the intent only to change a relationship (which would be judged as mild)? In Mary's case, although she thought she had taken a large amount, she didn't directly tell anyone; in essence it seemed as if she were gambling that she'd be rescued. Hence, the intent for Mary would be judged moderate.

3. *How the person was found.* If the person attempts suicide in an isolated place with little chance of being found, this is severe. If not isolated and the person doesn't directly communicate with another about his predicament, this is moderate; and if he communicates directly with someone, this is mild. Mary communicated indirectly and somewhat enigmatically with her mother: "I don't know if I'll see you." This would be judged moderate.

For Mary, then, the method is mild, the intent moderate, and with regard to how she was found, moderate. Overall, her suicide attempt would be judged moderate in severity.

Treatment

Now let us discuss treatment in general. We will begin by describing our Community Mental Health Program briefly. The program began in the fall of 1965 with a psychiatric social worker and a mental health nurse consultant. At present, we have a psychiatrist, four social workers, an anthropologist, a social work aide, and a research aide. We offer consultation to care-taking agencies on the reservation—schools, police, OEO, welfare, and so on—in addition to direct treatment, and we are beginning to work in community organization in several areas: program development, coordination of resources, making services more responsive to local conditions and local groups. We are engaged in a wide range of activities, and we hope to be able to demonstrate techniques which will be useful to other reservations and to health, welfare, and mental health agencies in other nonurban areas. We work mostly with patients on a referral basis, the referrals coming from the other caretaking agencies. Increasingly, we are not assuming primary responsibilities for patients but are sharing that responsibility with other agencies, both the referring agency and other agencies who come in as needed. Especially with suicidal patients, a broad, community-wide approach is indicated because of some of the peculiar treatment problems presented by this group.

Let us begin with the observation that the treatment approach will be determined by the needs of the individual patient. There is no general approach we have found to deal with the problems of self-destructive Indian people. However, experience suggests some generalizations about treatment which can be made for some of our patients:

1. With a high-risk patient, hospitalization should certainly be considered, but the patient should not be asked his opinion. It is often important that the suicidal patient see the therapist as in control of the situation.

2. Most importantly, we must constantly keep in mind our own tendency to deny the suicidal intent of the patient, for example, our tendency to be misled by a previously depressed patient who appears more cheerful.

3. Since the suicidal patient is usually isolated, he needs a relationship which can be maintained through his crisis period. After the crisis is over, we need to enlist the aid of available, meaningful people—resources for the patient. Even when these are available, our approach to a seriously suicidal patient will strongly emphasize our wish and intent and concern that the patient live. We need to evaluate the intents of the people to whom the patient will return; for example, it would be foolhardy to return a patient still in suicidal crisis to a home where his spouse wished him dead.

4. Patients who are suicidal are often difficult patients. They exude anger all over and in many ways. This indicates a need for the therapist to be aware of the negative feelings he may have about the patient. It also indicates a need for a backup system to reinforce the efforts of the family and what we call the "community helpers," and Dr. Dizmang in his article on the Northern Cheyenne called the "gatekeepers" to help the patient (*1*). This means regular, sustained consultation and mutual support for those who will be in closest contact with the patient.

5. Patients who are suicidal often need a wide variety of services. This requires a knowledge of available services on the part of those who are trying to help, and a service system which cooperates and is flexible enough to move quickly to meet the patient's needs.

6. Our data on previous contacts with the PHS Hospital in suicide attempts indicate that many cries for help are probably not heard. We need to be more aware of and make more of an effort to identify high-risk people, such as: Those with previous attempts; those who are clearly depressed; those, possibly, who begin to come to the hospital increasingly frequently, complaining of pains that don't make "sense" to the physician; young women, especially, with very close ties to one person and few other resources. This indicates a need for a good listening system, widespread education, and, again, sustained contact with possible listeners, especially listeners close to the patient who has already made a suicide attempt.

The Pine Ridge Experience

Now we want to suggest some questions to ask in thinking about suicide and self-destructive behavior in American Indian tribes and describe some information we have obtained on the Pine Ridge Reservation.

We need to ask what, and how big, is the problem and what are the characteristics of the people involved. How do suicide and suicide attempts differ and how are they similar when comparing the reservation with the problem in the United States as a whole? Is it possible, for example, that on the reservation suicides and suicide attempts more often involve another person as the agent in terms of getting oneself into a situation where one is beaten up or involved in an auto accident? Are suicide attempts on the reservation more often a combination of homicide and suicide? What is the constellation of factors necessary but not sufficient to account for suicides and suicide attempts? For example, in general, what are the attitudes and beliefs about dying, about selfinflicted deaths, and toward selfdestructive acts? Are there any general themes in the meanings of the precipitating events?

On the Pine Ridge Indian Reservation, aggressive feelings are usually dealt with indirectly (unless, of course, alcohol is involved), usually through gossip or avoidance. A review of the charts of the first 40 consecutive patients seen by the psychiatrist in our Community Mental Health Program indicates that the most common defenses that the patients used to deal with aggression were denial, depression, and the use of somatic complaints. In general, aggression is turned inward among these patients. In looking at these patients' dreams and early memories, we found 55 percent of the dreams and early memories dealt with problems around dependence-independence, that 40 percent dealt with problems of aggression, and only 5 percent dealt with problems related to sexuality (*7*). Interestingly, of the dreams and early memories related to aggression, 68 percent dealt with themes of being hurt, either by others or by one's self.

Now, let us review our Community Mental Health Program statistics regarding suicide and suicide attempts during the fiscal year July 1966 through June 1967. There were no successful suicides reported as such, but we have no idea how often cars were used, for example, to suicide. There were 25 suicide attempts seen, including five threats judged to be significant. Using a population base of 10,000 (estimated), this gives an attempted suicide rate of 250/100,000, or somewhat more than twice the rate reported by Shneidman and Farberow in Los Angeles.

The following figures are all related to suicide attempts, and this will show the information which is recorded for every recognized suicide attempt at Pine Ridge.

1. Age:
   96 percent were under 40.
   68 percent were under 29.
   36 percent were 19 or less.
2. Sex: 80 percent were women and 20 percent were men.
   (This more or less corresponds with the national statistics of seven women for every three men.)
3. Marital Status: 60 percent were single and 40 percent married.
   (This probably reflects the young age of many attempters.)
4. Blood Quantum: About 37 percent were full bloods and 63 percent were mixed bloods. (The percentage in the whole population is: Full bloods—48 percent; mixed bloods—52 percent.)
5. Severity:

	Percent	*Number*
Mild	68	17
Moderate	24	6
Severe	8	2

There was no significant relationship between severity and sex or age.

6. Method:

	Percent	*Number*
Hanging	7	2
Overdose	53	14
Wrist-cutting	19	5
Thoughts	19	5

7. Previous contacts with PHS Hospital in 26 attempts:

	Percent	*Number*
1 day previous	19	5
1 week previous (or 2–7 days)	15	4
Total	*34	9

8. Previous attempts:

	Percent	*Number*
No	68	15
Yes	31	7

9. Most common precipitating stresses:

	Percent	*Number*
a. Felt rejection by an important person	52	13
b. Interference in family by relatives moving in	16	4
c. Psychotic	12	3
d. Other	20	5

*Seen within 1 week of attempt.

10. Diagnosis (ranged through all possible diagnoses):

Neurotic—52 percent (depressive reaction—40 percent)
Psychotic—16 percent
Character Disorder—16 percent
No psychiatric diagnosis—16 percent

11. Dynamics:

The most frequent dynamics involved the disruption of a close hostile-dependent to symbiotic relationship with resultant extreme feeling of helplessness and anger which is turned inward.

12. Intent of suicide attempt:

	Percent	*Number*
a. To change an important relationship	13	52
b. To die	4	16
c. To get out of situation	5	20
d. Other	3	12

On the Pine Ridge Reservation, then, the modal patient who attempts suicide is most likely to have the following characteristics. The patient will be a young woman, under 29 and quite likely under 19, who is single and of mixed blood. The suicide attempt is mild and most likely accomplished by taking an overdose of medication. There is one chance in three that the patient has made a previous attempt and also that the patient has made some cry for help at the PHS Hospital within 1 week of the attempt. This is usually a clinic visit to a physician. Diagnostically the patient will have a neurosis. The attempt will probably be precipitated by a felt rejection of a person important and meaningful to the patient, who probably was involved in an intense hostile-dependent or symbiotic relationship with this other person. The suicide attempt is then used, usually, to reestablish the old relationship.

The Suicide Register

Now let us review the information recorded about a suicide attempt or suicide as recorded by the Community Mental Health Program. First, most suicide attempts reported to the hospital or coming into the emergency room are referred to us. As we are spending more staff time in outlying communities, we are also discovering more suicide attempts where the person does not come to any hospital for treatment, and we are recording these. Each suicide attempter is seen by a member of the Mental Health Program staff, and the following information is obtained and recorded:

1. Age.
2. Sex.
3. Residence. Does the person live in an isolated house or is the home in a rural cluster or village? We began gathering this information in the current fiscal year.
4. Marital status.
5. Blood quantum.
6. Precipitating stress.
7. Method.
8. Intent.
9. How the person was found.
10. Severity—determined from the last three above.
11. Previous contacts with the PHS Hospital. How long ago was the most recent contact?
12. Previous attempts. How many are known?
13. Psychiatric diagnosis (if the person was seen by the psychiatrist).
14. Dynamics.
15. Treatment—inpatient or outpatient, followed by whom, and so on.
16. A brief record of followup—after 3 months and after 6 months.

This information is gathered in a suicide register, which is kept in our office. The register enables us to maintain statistics on frequency and characteristics of the recognized attempted and completed suicides, such as those which I have reviewed. We have statistics for fiscal year 1967 and are gathering statistics for 1968.

Unreported Suicide Attempts

Earlier, we mentioned our speculation that suicide and self-destructive attempts may go unre-

ported on the reservation because they occur as automobile accidents or as an individual's placing himself in a situation where he is likely to be beaten up. We would like to briefly sketch some of our attempts to investigate this problem before going on. At this point we get into questions such as to what extent are automobile accidents and other accidents consciously or unconsciously determined by the injured person and are the dynamics involved similar to those we see in attempted and/or successful suicides. Here, the observations of Hirschfeld (*6*) are useful. In studies of persons involved in industrial accidents, he found that the individual had usually predicted the accident and that the dynamic involved was the conversation of an "unacceptable disability" into an "acceptable disability." Here, too, the fact that to be eligible for financial assistance an individual must be physically disabled, unless he or she is a mother with dependent children or over 65, is important. During the winter months financial assistance is available to anyone who is out of work, through the Bureau of Indian Affairs, Branch of Social Services. Recently, at a case conference with Bureau of Indian Affairs and State welfare workers and the Community Health aides, about a multiproblem family, we asked the question: "When did agencies try to work together to help this family?" The answer was: "Only when someone was injured or when there was child neglect or desertion." So one meaning of a self-destructive act, on our reservation, may be that this is what you do to get others (agencies) concerned about you, especially if you are an able-bodied man. We have to look at a whole continuum of self-destructive behavior: Accidents, the TB patient who understands his disease but refuses to accept treatment, some problem drinkers, and so on.

Our medical social worker is currently looking into all accidents coming into the emergency room at the Pine Ridge Hospital over a 6-month period in an effort to find out who has accidents, what are the common trends, and get some clues for further research. At the same time, he is doing a psychological autopsy of an individual who died in a three-car auto accident in September—and is finding material which suggests here, at least, this dramatic accident which took three lives was at least a suicide and perhaps a combination of suicide and homicide.

Special Problems of the Reservations

One of the major problems we encounter is in translating urban models of programs to Indian reservations, which can be characterized, negatively, by a lack of easy transportation, communication, and agency resources and, positively, by the large number of relatives available to most individuals and the importance of families, peer groups, and community members. Most of the literature on suicide prevention centers (and on other crisis-oriented agencies and organizations, such as Alcoholics Anonymous) describes these programs as relying on technological resources, such as the telephone and mass transit, that are not available on most reservations, and on a good backup system of agencies and services: Homemaker services, psychiatric services, family-service agencies, halfway houses, day hospitals, ambulance service, and so on.

The professional worker on a reservation, particularly if he has not worked in rural areas before, may find himself frustrated in his efforts to help patients for two reasons. First, patients may not come in regularly for appointments; and second, it will be difficult to find services needed by the patient, especially employment, housing, training, and sheltered situations, as are provided by halfway houses.

We shall discuss some possible ways of getting around these problems. Two major difficulties contribute to the frustration we face: First, a lack of coordination, of pulling together, among the various helpers who might be offering services to an individual, and a lack of knowledge on the part of the helpers of all the resources which might be appropriate to his case; second, a lack of continuity in our contacts—for example, the patient we might see once or twice following a crisis and then lose touch with because the patient does not keep appointments and then is not at home when we call on him. There are two areas we might look at now: First, how can we improve coordination; and second, how can we improve continuity (and also get into case finding—the identification of potentially self-destructive individuals).

We need an approach aimed at bringing many resources to bear on a patient while at the same time providing sustained contact with the patient by a helping person. We can think about scheduling case conferences periodically, in the communities where people live, with other helpers; the welfare workers, homemakers, public health nurses, community health aides, and so on, and with the community "gatekeepers," the people others turn to at the time of a crisis—clergy, VISTA volunteers, community leaders, Yuwipi (medicine men), and so on. There would be two purposes for such a program: case finding and case planning, that is, the case conference, would be set up to locate for the helpers the people in the community who are in need of help, to determine what help they need and to plan who in the group will do what. A refinement of this idea is the Community Service Center concept—bringing together all of the helping people in the community at a central location—near the post office say—where they can be available to community people—and to other helping people. This would also facilitate the growth of local community groups—perhaps volunteer workers, perhaps groups to consider community problems and act on them. When we get involved with this kind of local community case conference, we also get involved with people in new career positions, usually paid by the local OEO. These are community health aides, homemakers' aides, community development aides, and so on. We will say a few words about new careerists and then make a suggestion about new aide positions.

In our work in the isolated communities on the reservation, we have found the aides to be valuable coworkers. They usually are in the community 5 days a week, which means they often will know a great deal about the people we are working with and will be able to tell us of others who may need service. The aides are also able to provide much-needed continuity in patient contacts, whether on a daily or a weekly basis. Much of what the aide is able to do depends on the training the aides have received, and their supervision, in determining how far it is possible to go, and how willing the aides will be to explore new approaches to the treatment of troubled people.

In the Community Mental Health Program, we have at present two aide positions. One, the social work aide, assists the hospital social worker as a case aide; the other is a research assistant to our anthropologist. In addition, we are involved with a number of interested community groups in exploring the establishment of an alcoholism program involving the hiring of new careerists who will work with alcoholics. Possibly, these people will function as mental health aides, community-based, who will see many people involved in various kinds of self-destructive behavior and play a major role in organizing and coordinating the services used by them in providing continuity and also in watching for danger signals. Again, training and supervision are important here, as well as an adequate backup program—and this involves providing both services for patients and, more important, consultation and inservice training for the aides.

This brings us to the problem of whether to go in the direction of new program development or the strengthening of what we have already, or both. We have not resolved this yet, although ultimately, it seems to us, community agencies will need sustained, ongoing, backup services through such mechanisms as the case conference and ongoing consultation services in order to deal with the suicide problem (or self-destructive behavior problem). So the really basic work which needs to be done is in finding ways to spread some of our thinking on suicide as broadly as we can to a large system of community helpers and to increase the number of helpers and make them people who matter in the day-to-day lives of our patients.

We do not need to dwell on the problems of getting more cooperation or more community involvement, since these problems are universal. On our reservation, everyone is extremely busy and under a great deal of pressure, and time for coordinating, for education, or for just being together, is hard to come by. Also, roles are so well defined that often it is hard to see where each of us fits in in a collaborative venture of helping a patient which looks at the patient's needs, but not the agency's role or function. However, we have made a start at Pine Ridge, most significantly, in

holding our meetings in the communities where people live, not in the agency town, and in involving more helpers than the usual group of professional workers.

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SUICIDE AND SELF-DESTRUCTIVE BEHAVIOR ON THE CHEYENNE RIVER RESERVATION

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The Cheyenne River Indian Reservation is located on the plains of northern central South Dakota and is populated by approximately 3,700 Sioux Indians. The reservation, bordered on the east by the Missouri River, measures about 100 miles in length by 70 miles in width. The character of the reservation is predominantly rural, with much of the population living in small (Indian) communities over the reservation, many of which are very isolated by modern standards of travel and communication. The rest of the population lives either in or around the small towns on the reservation or out on the prairie. Those who live around the small towns on the reservation generally are onlookers into the community life, having little voice in the economic and political affairs of the town.

There is virtually no industry on the Cheyenne River Reservation, and most of the jobs either are temporary, being provided by the agencies of the poverty program, or are seasonal, being available only during the warm months, such as ranch work. For this reason, the Indian is forced either to leave the reservation in search of a job or to stay and accept low-paying jobs or relief. If he stays on the reservation, he is likely to be caught in a crippling web of dependency, which may satisfy his physical needs but which denies him the pride and satisfaction of self-sufficiency.

On the other hand, if he does choose to leave the reservation, the Indian gives up the spiritual security of the familiar and ventures forth into an unfamiliar world for which he is usually grossly unprepared. He lacks the skills and the experience needed to exist in a strange job in an unfamiliar place, he feels utterly alone and isolated, and most importantly, he lacks the necessary confidence in himself. He feels unable to compete with the non-Indians on an equal basis, and the sense of inferiority which he has learned saps his courage and determination. As one Indian lady on the Cheyenne River Reservation stated it, "When I was young I was told, 'Listen to him, he's a white man—he's smart,' and although I know I'm as good as a white person, I don't feel that I am." Thus we see that not only the attitudes of whites towards Indians, but also the attitude of Indians toward themselves and their race, fosters and perpetuates this feeling of inferiority.

On the Cheyenne River Reservation the housing and the living conditions are very poor. Alcoholism and violence rates are high. There is not the feeling of closeness and helpfulness among the Indians that one might hope for, and people suffer from the same feeling of isolation in the small Indian communities that is prevalent in the larger cities across the United States. Social disorganization is rampant, and the family is not the source of strength and comfort it might be.

Admittedly this very brief picture of the Cheyenne River Reservation emphasizes the negative aspect of the total environment, but this is the way it looks to the Indian who considers or engages in suicide or other self-destructive behavior. The picture could easily be painted in a positive light if one ignored these negative aspects, but then it would not be seen in the hopeless way that many of those who are caught in self-destructive behavior view it.

Included in forms of self-destructive behavior other than suicide are chronic disregard for proper care of one's health; extreme violence toward others, which places the self in danger; alcoholism; and other dangerous actions such as drunken and reckless driving.

Forms of self-destructive behavior other than suicide are included in this discussion because the dynamics for them seem to be the same; and although we cannot say that all participants in such self-destructive actions are intent on actually killing themselves, neither can we say that all suicide attempts or "gestures" had death as their antici-

pated end result. Still, however, such behavior is dangerous both to the self and to others and offers a hint of the desperation that is behind it.

In the past year on the Cheyenne River Reservation, 15 suicide episodes were reported to the Public Health Service Indian Hospital, none of which resulted in death. Some of these could be called "gestures," in that the person claimed not to have been trying to kill himself but "just did not know what else to do." Although these cannot be discounted as not being suicidal, their act seemed to be more of a spontaneous, impulsive expression of anxiety and desperation than an actual attempt to escape through death.

Of those cases reported, some where admitted to the hospital because of the seriousness of their self-inflicted injury, some were reported by the tribal police and jail personnel, and some were reported by friends or relatives who were anxious for the safety of the person. It is difficult to estimate the number of attempts which were not reported, but due to the personal nature of the causes of the attempts, certainly the number is large. In addition, a number of others have admitted during counseling sessions about other problems that they have considered suicide at one time or another.

Of the 15 who were reported, 13 were between the ages of 15 and 21, and the other two were in their mid-thirties. Of the 13 younger ones, 10 were girls. Thus the emphasis of this group of reported suicides is on the youth of those involved.

What is involved in these suicide attempts? Why these young people, and why the particular time? My impressions will be given here, and while these dynamics do not operate to such a degree in all young people in the Cheyenne River Reservation, they do seems to be present in a significant portion of them.

One difficulty these young people faced was the conflict of cultural transition. There is very definitely a modification, if not a complete change, of the old organization of values held by the Indian people. While many of the older people may be able to retain their identity with the old Indian ways, and to gain stability from this identification, the younger Indian has difficulty adopting these ways because of the great changes in the society over the years, and because he has already adopted some, but not all, of the ways of the white man. These two systems of morals and values do not always fit together, so that gaps and conflicts result, and the younger Indians grow up without being able to identify themselves either with their Indian heritage or as a white person. This lack of identity and stability causes tremendous difficulty to the adolescent who is already caught up in a sea of impulses, needs, wishes, and uncertainty.

The cultural transition causes difficulty not only in identification, but also in knowing how to handle the temptations and stresses of entering adulthood. As the ways of his parents do not always fit the situation in which he finds himself, often the younger Indian is not able to use his parents' behavior as a way of knowing how to handle the situation, and thus the prevalent way of teaching children by example often does not suffice. Several of the 13 young people who attempted suicide complained that they had never been told what to do and not to do by their parents. One girl expressed this thought by saying desperately, "What am I supposed to do? I don't know! My mother never talked to me about what is right and wrong. She left me to find out for myself." Apparently this conflict robbed them of the sense of security that comes from direction by others before the individual feels ready to make his own decisions.

Closely related to this practice of child instruction by example is a profound respect for individual autonomy, even to the point of allowing a child to make his own decisions regarding school attendance and medical care. This dates from an era in which the role expectations were fairly well defined in the tribe, so that by observing the available models of behavior and by imitating them a child was socialized. With patterns of behavior less clear-cut and with the vastly changed situations, such autonomy apparently is often taken advantage of by some children, and in some cases is perverted into giving the child his way all of the time, thus making him into a small tyrant in the family. Several of those who attempted suicide were able to verbalize the complaint of having been given their way too often, having been overindulged in getting whatever they wanted, and stated they felt this had been harmful to them. The fact that it was harmful can be seen by the fact that at least half of the young people, who attempted suicide did so in such a fashion as to manipulate those around them in order to get what they wanted. This spoiling resulted in very self-centered and immature reactions to others, in which other people were objects to be manipulated to get one's own way. As the result, these young people were left with an inability to take no for an answer,

and with a lack of any ability to govern their own impulses or to accept any limitation imposed upon them.

Evident in most of these reported cases was an extremely low self-concept. There was no pride in being Indian. Rather there was a feeling that being Indian was of little value. There was a feeling that neither their parents nor anyone else around them cared for them, and part of the low self-image seemed to be due to the fact that since they felt that no one else valued them, they did not adopt any concept of themselves as being valuable. This lack of self-worth or self-respect was most evident in the remark of one girl, "Did you notice that I don't give a damn about myself?" and may be important in the choice of a target for aggression, whether it will be the self or another.

This dynamic of low self-concept is important among the older people on the Cheyenne River Reservation also, although associated more with alcoholism and violence in this group than with suicides. Especially for the man in the older age group—meaning those over 30—there is a crippling lack of lasting satisfaction available in any form. The previously mentioned inability to be the bread winner for the family; the fact that the mother and grandmother are the significant teachers and disciplinarians of the children; in some cases the inability even to father children where the mother elects birth control measures without consulting the father; the dependency on others to provide all services to his family—all of these combine to prevent the man from gaining a feeling of satisfaction or self-importance. He has no role, and often is not important to the family in any concrete way. In addition to increasing his futility, the uselessness and dependency generate more hostility and result in more frequent turning to alcohol as an escape or release. In some cases, alcohol and violence provide a way to gain esteem in the eyes of others by the only means available—through rough or daring behavior. As this reliance on alcohol usually only makes the problems worse, it may then be relied on to an even greater degree, setting up a vicious cycle of drinking and disorganization.

Also important in almost every one of the cases of suicide and violence related to the use of alcohol was the practice of holding in all of the pain, anger, worry—holding in every emotion—until the emotional pressure became so great that some problem triggered a response that was out of all proportion to the incident that caused it. Often these people gave the impression that they were well adjusted, and frequently there was no hint of the inner stress until the pressure became so great that it could not be held back. This dynamic also seems most relevant in drinking and brutality, when a person who is very retiring while sober becomes very abusive and even brutal while drinking.

The Indians on the Cheyenne River Reservation who were reported for being involved in suicide episodes did seem to fit the traditional picture of the Indian as one who endures great pain without crying out, at least until the pain becomes unendurable. This way of handling stress has proved to be used as much for aggression as for anxiety, and often the actual attempt at suicide was an outlet for aggression, much as drinking and fighting provide an outlet for the aggression of other people. The suicidal act might take the aggression out on the self, but often it was directed toward another person, in an attempt to hurt that person by making him feel responsible for the act, thereby producing in him a feeling of guilt.

How can the Indian be assisted to resolve some of the underlying causes of self-destructive behavior described above? There are the long-term goals of better housing, providing jobs through industry on the reservation, and upgrading the environment as much as possible through better sanitation, health care, recreation, and education.

There is also a need for data collection so that approaches toward solutions will be based on accurate knowledge of the problem rather than on descriptive materials alone. Indians must be involved in the solutions to their problems, and solutions must not be imposed upon them in such a way as to cause rejection by those they are designed to help.

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